South Australian
Patient Safety Report
2014 - 2015
Acknowledgements

The Safety and Quality Unit 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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### Definitions

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<th>Term</th>
<th>Description</th>
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<td>Challenging behaviour</td>
<td>Challenging behaviour has the potential to, or does, stop, interrupt or limit the ability for a health service or care to be provided in a way that is safe for both consumer and staff; results in a person feeling unsafe or threatened, or feeling that intervention or withdrawal is warranted to avoid harm.</td>
</tr>
<tr>
<td>Code black</td>
<td>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 threatening behaviours can be exhibited by a patient or by other person(s). It is a request for urgent / emergency assistance.</td>
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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>
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<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>
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<td>ISBAR</td>
<td>The mnemonic for a standardised approach to clinical handover (Identify, Situation, Background, Assessment, Recommendation).</td>
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<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>
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<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>
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<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>
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<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>
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<td>Safety Learning System (SLS)</td>
<td>An electronic system for the reporting and management of incidents and consumer feedback across SA Health.</td>
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<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>
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<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>
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Executive summary

This is the ninth 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. 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, 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 2011-12, 2.8%; 2012-13, 1.6%; 1.4% in 2013-14 to 0.9% in 2014-15. In particular, improvement has been seen in the number and proportion of injuries caused by falling in hospitals: 2011-12, 2.9% (n=210) to 1.4 % (n=143) in 2014-15.
- 100% of public health services assessed against the National Safety and Quality Health Service Standards were awarded accreditation.
- 29,992 online eLearning Courses on various safety and quality topics, including aseptic technique, clinical handover, falls, challenging behaviour in 2014-15.
- The BloodMove program won the national 2014 Australian Council Healthcare Standards (ACHS) Award for Non-Clinical Service Delivery and the inaugural National Blood Management Award for Excellence in a Public/Private Health Sector Collaboration.
- Measuring a consumer’s experience continued in 2014-15 with 2316 consumers being interviewed. Nearly 88% of patients rated the overall quality of service as ‘very good’ or ‘good’, and 91% said they would recommend the hospital to a relative or friend, a slight improvement from 90% in the previous report.
- Measuring Consumer Experience Survey identified the following domains of care that achieved greater than the state benchmark of 85.
  - Treated with respect and dignity – 92.8
  - Doctors – 88
  - Nurses – 89.6
  - Cleanliness – 89.6
  - Pain control – 89.6
  - Privacy – 92.8
- Release of the Challenging Behaviour Strategy, including policy directive, toolkit, infographic, metrics and communication strategy and a targeted SA Ambulance Campaign. Within 24 hours of posting the SAAS campaign video on Facebook it had reached 2.3 million people, had over 800,000 views and over 70,000 people had liked, shared or made a comment.

1 National Safety and Quality Health Service Standards, Australian Commission on Safety and Quality in Health Care, 2011
2 Australian Commission on Safety and Quality for Health Care, Australian Safety and Quality Framework 2010.
National Safety and Quality Health Services Standards

Standard 1  
Governance for Safety and Quality in health service organisations

Standard 2  
Partnering with Consumers

Standard 3  
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

A better way to care

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 2014-15 work has continued to ensure a robust policy framework is available to support the National Safety and Quality Health Service Standards (NSQHSS). 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.

Further information about policy development related to specific standards is available in the relevant sections of this report.

1.1.2 Safety and Quality governance structure

³ National Safety and Quality Health Service Standards (September 2011), Australian Commission on Safety and Quality in Health Care (ACSQHC)
1.1.3 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

1.1.3.1 Accreditation resource guides

The SA Health Accreditation resource guides were developed in 2013, and are designed 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 (NSQHS) Standards.

The ten accreditation resource guides provide a combination of resources (policies, guidelines and tools), assist health services in identifying examples of evidence to demonstrate how to meet individual actions.

The resources are working documents that can be used by health services in their planning for assessment against the NSQHS Standards, and are 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

In 2014-15, the Accreditation resource guides views are reported in table 1.

Table 1: SA Health Accreditation resource guides views 2014-15

<table>
<thead>
<tr>
<th>SA Health Accreditation resource guide</th>
<th>Number</th>
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<tbody>
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<td>Standard 1 – Governance for Safety and Quality in Health Care</td>
<td>2081</td>
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<td>Standard 2 – Partnering with Consumers</td>
<td>642</td>
</tr>
<tr>
<td>Standard 3 – Preventing and Controlling Healthcare Associated Infections</td>
<td>2425</td>
</tr>
<tr>
<td>Standard 4 – Medication Safety</td>
<td>3843</td>
</tr>
<tr>
<td>Standard 5 – Patient identification and procedure matching</td>
<td>2245</td>
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<tr>
<td>Standard 6 – Clinical Handover</td>
<td>1445</td>
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<tr>
<td>Standard 7 – Blood and Blood products</td>
<td>1491</td>
</tr>
<tr>
<td>Standard 8 – Preventing and managing pressure injuries</td>
<td>1473</td>
</tr>
<tr>
<td>Standard 9 – Recognising and responding to clinical deterioration</td>
<td>2046</td>
</tr>
<tr>
<td>Standard 10 – Preventing falls and harm from falls</td>
<td>1710</td>
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</table>

Item 1: 10 SA Health Accreditation resource guides
1.1.3.2 Accreditation outcomes

From July 2014 to June 2015, 47 public health services were assessed to the National Safety and Quality Health Service Standards, including:

- 43 hospitals (including mental health services)
- 1 state wide service
- 3 community services

Of those:

- 19 were assessed to Standards 1, 2 and 3 (40%)
- 28 were assessed to Standards 1 to 10 (60%)

Approximately 70% of public health services met all 209 core actions at initial assessment, with no recommendations. The services that did not initially meet all core actions, underwent re-assessment after 90 days and met all core actions at the final assessment.

1.1.3.3 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 to 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 the 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.

SA Health performed well nationally against the core actions, with only two actions in relation to Standard 8 – Preventing and Managing Pressure Injuries requiring improvement from the initial assessment. All core actions relating to Standards 1-7, 9 and 10 were met by all services at initial assessment. Further work and improvements in relation to Standard 8 will be a focus in 2015-16.

Graph 1: National and state (NSQHSS 8) 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
Whilst core actions are considered to be critical safety and quality requirements and 100% of core actions must be met in order to achieve accreditation, there are also 47 developmental actions.

These developmental actions are focussed on future efforts and resources to improve patient safety and quality, but do not need to be fully met in order to achieve accreditation. Approximately 78% of developmental actions were met by all public health services. The developmental actions that were not met, and which will be an aspirational target to meet in future assessments, are summarised in table 2.

Table 2: NSQHS Standard developmental actions that were not met

<table>
<thead>
<tr>
<th>NSQHSS</th>
<th>Actions required</th>
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<tr>
<td>4.8.1</td>
<td>Current medicines are documented and reconciled at admission and transfer of care between healthcare settings.</td>
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<tr>
<td>7.9.2</td>
<td>Plans for care that include the use of blood and blood products are developed in partnership with patients and carers.</td>
</tr>
<tr>
<td>8.7.3</td>
<td>Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan.</td>
</tr>
<tr>
<td>8.10.1</td>
<td>Pressure injury management plans are developed in partnership with patients and carers.</td>
</tr>
<tr>
<td>9.8.2.</td>
<td>Advance care plans are other treatment-limiting orders are documented in the patient clinical record.</td>
</tr>
<tr>
<td>9.9.1</td>
<td>Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response.</td>
</tr>
<tr>
<td>9.9.2</td>
<td>Information about the system for family escalation of care is provided to patients, families and carers.</td>
</tr>
<tr>
<td>9.9.3</td>
<td>The performance and effectiveness of the system for family escalation of care is periodically reviewed.</td>
</tr>
<tr>
<td>9.9.4</td>
<td>Action is taken to improve the system performance for family escalation of care.</td>
</tr>
<tr>
<td>10.10.1</td>
<td>Falls prevention plans are developed in partnership with patients and carers.</td>
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1.1.4 Learning and development

In 2014-15, SA Health established a statewide Learning and Development Directorate to increase quality and efficiency and reduce duplication in the provision of learning and development. Since this time, the Safety and Quality Unit, Department for Health and Ageing (DHA) have worked collaboratively with the Learning and Development Directorate and other SA Health organisations to further leverage learning and development as a means to improve safety and quality. These initiatives include the Perinatal Emergency Education Strategy proof of concept and the review of TeamSTEPPS® curriculum and online learning initiatives.

1.1.4.1 Perinatal Emergency Education Strategy proof of concept

The Perinatal Emergency Education Strategy has introduced a number of educational resources for clinical staff involved in the care of obstetric patients and neonates across SA Health. These resources; Practical Obstetric Multi-Professional Training (PROMPT), Neonatal Resuscitation Program (NRP) and Fetal Surveillance Education Program (FSEP) will support ongoing development in the areas of obstetric emergency management, new born resuscitation and foetal electronic monitoring. The project has been established to support the implementation of effective, sustainable, equitable learning and development in perinatal emergency care for all clinical staff across SA Health.
Following the successful introduction of the Strategy across Country Health SA Local Health Network (CHSALHN), Southern Adelaide Local Health Network (SALHN), Northern Adelaide Local Health Network (NALHN) and Women’s and Children’s Health Network (WHCN), there was an identified need to establish the Strategy onto a state-wide Learning Management System (LMS).

The Perinatal Emergency Education Strategy proof of concept is being implemented to:

- utilise the Totora LMS to host and deliver the Perinatal Emergency Education Strategy through a collaboration between the Safety and Quality Unit, DHA, WCHN and Central Adelaide LHN (CALHN)
- coordinate face to face training, online eLearning and blended learning activity for the perinatal emergency resources
- implement a plugin to enable the Neonatal Resuscitation Program (NRP) online residing on the WCHN LMS to be accessed through the Totara LMS
- develop administrative systems including booking face to face training through the LMS, a calendar, manager approval, notification processes and reporting.

The project has been extended due to delayed progress with the procurement process and is due for completion in December 2015.

1.1.4.2 TeamSTEPPS®

TeamSTEPPS® is a program designed to improve healthcare workers’ teamwork and communication skills and establish sustainable team structures and processes to improve safety and quality. Teams of healthcare workers design and implement safety and quality improvements identified from undertaking a review of local safety and quality data and teamwork and communication processes. Progress has been made in the following areas:

- Peter Hibbert completed a Delivering Team STEPPS® review in 2014. This recommended decreasing demands on participating clinicians’ time and reducing the duration of the two and a half day face to face training. Adaption of the TeamSTEPPS® curriculum to a blended learning model using a combination of eLearning and face to face learning was widely supported. Online eLearning modules for teamwork and coaching have been developed and are currently being trialled.
- TeamSTEPPS® was transferred from the Safety and Quality Unit to the Learning and Development Directorate in June 2015. Work is focusing on establishing a sustainable model and structure for teamwork improvement through the achievement of patient safety and quality improvement goals through teamwork and communication interventions.
- The Royal Adelaide Hospital Emergency Department and the Rural and Remote Mental Health Network team have commenced working with TeamSTEPPS®.
- A review of the TeamSTEPPS® curriculum has commenced to support transition to a blended learning model, stronger linkages to the NSQHS standards and ongoing sustainability.

1.1.4.3 Safety and Quality online eLearning courses

SA Health is committed to ensuring a safe, high quality, accessible health care system for all South Australians. The Safety and Quality Unit 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.

The Safety and Quality Unit have worked collaboratively with Digital Media at WCHN and content experts to develop online courses aligned with the National Standards and supporting TeamSTEPPS®. WHCN developed and released a Moodle plug in which enables access to courses and recording of results from local LMSs.
Courses released from July 2014 include:

- An introduction to preventing and responding challenging behaviour
- High risk medications – an introduction
- High risk medications – insulin
- Minimising restrictive practices
- Safe Use of Personal Protective Equipment (PPE)
- Skills to Improve Teamwork.

**Picture 1: Safety and Quality online eLearning courses screenshot**
1.1.4.4 An introduction to preventing and responding to challenging behaviour

The Challenging behaviour online eLearning course is intended for all staff as an introduction to challenging behaviour, and about the strategies that can be put into place to prevent and, when necessary, respond to these incidents. The course presents the consumer and worker perspectives in challenging behaviour settings. Core elements of the course are:

- what is challenging behaviour, when and where does it occur, and what can trigger it?
- prevention strategies, designed to assist services to implement proactive actions
- actions to be taken at each stage of an incident - early intervention, during and after, including when and how staff can get assistance during and after an event, and follow-up with consumers to promote recovery.

Completing the course will assist staff to identify what other training their role may require, and key legislation and policy requirements.

Picture 2: Challenging behaviour online eLearning course screenshot
1.1.4.5 High Risk Medicines, an introduction

The High Risk Medicines online eLearning course is an interactive and engaging online learning experience designed to equip staff with the knowledge and strategies required to prevent errors with high risk medicines. It complies with the SA Health High Risk Medicines Management Policy Directive and is intended for all staff involved in medicines management. The online eLearning module takes about 30 minutes to complete.

Picture 3: High risk medicines online eLearning course screenshot

Medicines are the most common intervention used in health care and a key component of disease management and prevention. When used safely and appropriately, medicines provide significant health benefits to many patients. Medicines can however have undesirable effects, particularly if they are used incorrectly.

The system used to manage medicines in hospitals is often described using the medication management cycle. Medication errors can occur at any step of the medication management cycle. In South Australian hospitals, medication incidents are the second most common adverse event reported, accounting for approximately 20% of incidents reported. It is also widely acknowledged that incidents are under-reported.
1.1.4.6 High Risk Medicines – Insulin

Insulin is highly effective when used appropriately but it is also recognised as being one of the top five medicines reported in global incident monitoring systems. The second in the series, this online course is designed to raise front line staff awareness of errors that commonly occur with insulin and support them in developing strategies to minimise opportunities for error.

The course takes about 60 minutes to complete and is suitable for contribution to continuing professional development points. It can be completed in stages which you can return to later and a certificate is downloadable on successful completion of the self-assessment questions.

Picture 4: High risk medicines - Insulin online eLearning course screenshot

Safe communication

Safe communication of medicines is needed at all steps of the medication management cycle to ensure insulin is managed safely.

Click on the headings below to find out more.

- Obtaining the best possible medication history
- Medication reconciliation
- Communicating written medicine orders clearly
- Communicating verbal orders clearly

Safety principles for communication about insulin

- Never use unsafe abbreviations
  - abbreviations such as 'IU' or 'U' for units can lead to inadvertent overdoses of insulin and should never be used.

- Prescribe insulin by brand name
  - while generic names are usually recommended when prescribing medicines, insulin should be prescribed using the full brand name to improve clarity and reduce confusion.

- Specify the type of administration device
  - specify if using a vial, cartridge, or pen to ensure the correct device is used.

- Always clarify unclear orders
  - check with the prescriber and other sources if needed
  - orders should be crossed out by the prescriber crossing out the order and writing new orders.
1.1.4.7 Minimising restrictive practices

The Minimising restrictive practice online eLearning course is intended as an introduction to the range of issues that healthcare providers must reflect upon when faced with a situation where restraint or seclusion is being considered as an option in resolving a challenging interaction with a consumer. The course covers actions to take before, during and after. At the end of the course, participants will be able to:

> describe what restrictive practices are, and the risks associated with them
> identify the triggers and contributing factors leading to restrictive practices
> discuss actions that can prevent the use of restraint and seclusion
> explain the effect of restraint or seclusion on consumers and staff
> describe safe systems of work for getting assistance and back up
> identify actions that will optimise recovery for both the consumer and staff following an incident of restraint or seclusion.

The course includes interactive activities and scenarios, and reflects the Minimising Restrictive Practices policy directive.

Picture 5: Minimising restrictive practices online eLearning course screenshot

**SA Ambulance Service**

SAAS staff are regularly confronted with potentially dangerous situations that may lead to the use of restraint nets and/or police involvement.

**Scenario**

John is a 17 year old who is completing Year 12. He has become increasingly distant from his parents and school friends recently but has been regularly catching up with a neighbour who is a few years older than him. He has lost weight and refused to play tennis despite being the best on the school team. He is showing less interest in his appearance.

Watch the video and observe the interactions between John and the SAAS staff.
1.1.4.8 Safe Use of Personal Protective Equipment (PPE)

The Safe Use of Personal Protective Equipment online eLearning course is intended for staff that are required to use personal protective equipment (PPE) during their work activities to prevent the spread of infection to patients and staff. The course enables learners to recognise the importance of wearing appropriate PPE correctly, when it is required during clinical practice, and its safe removal.

Picture 6: Safe Use of Personal Protective Equipment (PPE) online eLearning course screenshot
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1.1.4.9 Course completions
During 2014-15, 29982 of these courses were completed, and in some cases earning the participant continuing professional development (CPD) points.

Table 3: Safety and Quality online eLearning course completions 2014-15

<table>
<thead>
<tr>
<th>Safety and Quality online eLearning courses</th>
<th>Completions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aseptic technique</td>
<td>6434</td>
</tr>
<tr>
<td>Clinical handover</td>
<td>4887</td>
</tr>
<tr>
<td>Falls prevention</td>
<td>4836</td>
</tr>
<tr>
<td>Labelling for safety #</td>
<td>2954</td>
</tr>
<tr>
<td>Safe use of Personal Protective Equipment (PPE)</td>
<td>2875</td>
</tr>
<tr>
<td>An introduction to high risk medicines #</td>
<td>2807</td>
</tr>
<tr>
<td>High risk medicines: Insulin #</td>
<td>1586</td>
</tr>
<tr>
<td>An introduction to preventing and responding to challenging behaviour (Release June 2015)</td>
<td>1217</td>
</tr>
<tr>
<td>TeamSTEPPS – introduction – Why do we having training about teamwork?</td>
<td>1098</td>
</tr>
<tr>
<td>TeamSTEPPS – skills to improve teamwork*</td>
<td>878</td>
</tr>
<tr>
<td>TeamSTEPPS – master trainer – observation*</td>
<td>285</td>
</tr>
<tr>
<td>TeamSTEPPS – refresher coaching*</td>
<td>115</td>
</tr>
<tr>
<td>Total</td>
<td>29972</td>
</tr>
</tbody>
</table>

Medication safety – separated out total#                                         | 7347        |
TeamSTEPPS – separated out total*                                                 | 2376        |

In 2015-16, online eLearning courses will be available on:
> Introduction to Safety and Quality
> Partnering with Consumers and Community
> Open Disclosure
> Resuscitation Planning

The Safety and Quality online eLearning courses are available for staff via the SA Health intranet site.
1.1.5 Safety and Quality metrics

An essential part of improving the safety and quality of the care provided to patients / consumers is the gathering, analysis and use of information regarding clinical performance. Health services should have access to a clearly defined set of safety and quality information that is gathered and consolidated into meaningful indicators for clinicians, managers, consumers and the executive.

1.1.5.1 Local Health Networks Analytics and Reporting Service (LARS)

The Local Health Networks Analytics and Reporting Service (LARS) was established in late 2013 to provide performance reporting information to the Local Health Networks. Since that time it has continued to grow and develop and now integrates data from over 30 health information systems into a single web-based portal that provides data on a range of topics in a variety of formats, including predefined reports, dashboards, scorecards and analytical cubes to allow adhoc reporting.

A focus over the past 12 months has been the integration of additional data to support safety and quality and clinical reporting priorities. The following systems have been added as sources over the past 12 months:

- Infection control system
- Practitioner credentialling system
- Work, Health and Safety data
- Allied health systems (CME)
- Nurse rostering systems (PROACT)
- Mental health systems (CBIS)
- Patient costing system and national benchmarking data (IHPA)

Together with the existing data within the system, this has facilitated the development of the following:

- Stroke clinical dashboard
- Incidents analytic
- Nursing dashboard
- Safety and quality scorecard
- Mental health incident reporting and dashboard
- Pathways to care reporting.

1.1.5.2 Clinical data strategy

The SA Health Clinical Data Steering Committee has been established and met for the first time in May 2015. The purpose of this committee is to:

- provide expert clinical and technical advice and recommendations on patient care, patient safety and new initiative requirements analysis based on clinical priorities
- provide advice in relation to the priority set for the specification and development of clinical indicators and datasets
- focus on the specification of indicators and datasets that address the quality of health care
- make recommendations to the Transforming Health Board and SA Health Strategic Safety and Quality Committee on learning and development requirements to support analysis and use of information in clinical practice.
The deliverables of this committee are a strategic action plan which is aligned to the national and state agenda includes:

> establishing indicators and developing datasets
> analysing and interpreting information
> publishing and reporting
> education and training requirements
> communication plan
> a detailed clinical data/reporting management plan
> standard set of management and clinical measures that clinical unit heads need to enable them to routinely assess the performance of their service and,
> specific sets of clinical indicators for clinical specialities.

**Picture 7: Clinical data strategy - data collection systems**
1.1.6 Authorisations under Part 7 of the Health Care Act 2008 (SA)

As outlined in previous Patient Safety Reports 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 Unit processes applications for authorisations from both the private and public sectors for consideration by the Minister for Health. As at 30 June 2015 there were 41 activities/committees authorised under the Act.
1.2 Clinical practice

1.2.1 Clinical networks

The Statewide Clinical Network Chairs engaged 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 Networks continued their work until 30 June 2015. New clinical engagement and advisory committee structures have been established to guide the implementation of Transforming Health; these structures took over responsibility of clinical engagement from 1 July 2015 and the most senior committee is the Ministerial Clinical Advisory Group. Work undertaken by the Clinical Networks will be undertaken within the new clinical engagement structure or within SA Health as required.

The Clinical Networks’ key activities for 2014-15 include:

1.2.1.1 Cardiology

The Cardiology Clinical Network key activities include:

- the cardiac genetics referral system for South Australia was finalised disseminated and is now operational in each Local Health Network
- developed and commenced a pilot at the Flinders Medical Centre of the chest pain pathway to assess effectiveness
- the network conducted two audits of cardiac rehabilitation services using the standard minimum dataset for cardiac rehabilitation services, which the Network developed previously and which were adopted in metropolitan and country public hospitals.

1.2.1.2 Child health

The Child Health Clinical Network (CHCN):

- conducted a trial of the ‘National Paediatric Toolkit’ providing 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.
- supported the Women’s and Children’s Health Network to implement the National Standards for Children in Out Of Home Care (OOHC) specifically the comprehensive assessments when entering OOHC.
- six statewide Paediatric Clinical Practice Guidelines developed by the Network were published in 2014-15:
  - Seizures
  - Common Ear Problems
  - Anaphylaxis
  - Constipation
  - Burns
  - Pain and Opioid Safety
- developed referral pathways for Child and Family Health Service (CaFHS) nurses for infants with failure to thrive
- developed a children and young people with HIV model of care.

The CHCN has provided advice to SA Health on a broad range of issues including:

- Transforming Health.
- National Child and Youth Strategic Framework for Health.
- National Breastfeeding Strategy.
- Review of the Queensland Primary Care Manual for its application in Country Health SA Local Health Network.
National Framework for Health Services for Aboriginal and Torres Islander Children and Families.

Department for Education and Child Development's (DECD) Health Support Planning in Education and Children's Services Standards.

General Practitioners and the use of the Child and Family Health Centres' Blue Book.

Australian Medical Council Limited's review of the Education and Training Programs of the Royal Australasian College of Physicians.

South Australian Youth Mental Health Services.

The Child and Adolescent Mental Health Service model of care.

Families SA model of care.

SA Child Development and Wellbeing Bill.


Other contributions were made to the following:

Input into SA Health’s contribution to:
- Allied Health Workers in Department for Education and Child Development’s (DECD) Children’s Centre Professional Development application for funds and program
- Child Protection-Mandatory Notification of actual or suspected child abuse or neglect (0-18 years) Policy Directive review
- DECD’s Online Child Abuse Reporting Line (eCARL)

SA Health Children’s Strategy Action Group

DECD Senior Officer Group

SA Health’s National Disability Insurance Scheme Implementation Committee

Children’s Healthcare Australasia’s Consumer Participation and Family Centred Care Special Interest Group

National Clinical Networks Forum

1.2.1.3 Maternal and neonatal

In 2014-15, the Maternal and neonatal network key activities include:

- improved cultural awareness in perinatal care for Aboriginal and Torres Strait Islander (ATSI) women in SA with the inclusion of culturally appropriate direction(s) for care within the SA Perinatal Practice guidelines. These were developed in consultation with aboriginal elder women and perinatal clinicians from across South Australia. Ongoing support for this consultation has been secured in a sustainable process where aboriginal representatives will participate in the development and review of all perinatal practice guidelines
- sustained the ongoing development and review of Maternal and Neonatal clinical practice guidelines; thus supporting safe and quality perianal care in SA. These are available via the web, iPhone and iPad devices and subsequently improve access for perinatal care providers in rural and remote areas
- contributed to safe perinatal care across SA by facilitating the SA Perinatal Consultant Advice Line whereby a specialist Obstetrician and Neonatologist are available on call 24/7 for advice regarding pregnant women and/or neonates with complex clinical needs.
- sustained the ongoing development and review of statewide perinatal clinical policies and standards
- contributed to improved reporting by perinatal services staff to the SA Health Work Health and Safety: Safety Learning System. Working in collaboration with the SA Health Safety and Quality Operational Committee developed a more specific reporting framework for maternal and neonate reports
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- supported the statewide implementation of the National Maternity Services Plan
- supported the strategic direction and leadership to improve the SA immunisation program
- contributed to improved clinical practice related to the management of Post-Partum Haemorrhage (PPH) with a review those clinical practices related to PPH undertaken in collaboration with SA Health Safety and Quality.
- contributed to, in collaboration with SA infant health care providers, an improved review and monitoring of health care strategies and programs aimed at ensuring infants in SA have the best opportunity of a healthy start to life
- supported the review of the SA Pregnancy Record in collaboration with key stakeholders to optimise continuity of care, women’s participation in her care and to promote early and appropriate use of antenatal services, particularly among disadvantaged groups
- supported the review of the SA GP Obstetric Shared Care Protocols in collaboration with GPs, GP partners organisation and perinatal care providers to support women choosing to maximise their antenatal care provided by their GP in coordination with the participating public hospital where they plan to birth.

1.2.1.4 Mental health
In 2014-15, the Mental Health Clinical Network:
- completed a report on enhancing service provision and cross-sector collaboration for consumers with an intellectual disability who are experiencing mental illness
- researched suicide prevention tools for Emergency Department environments and assisted the organisation of a trial of the Columbia Suicide Severity Rating Scale in Northern Adelaide Local Health Network (NALHN), which will commence in 2015-16.

1.2.1.5 Older people
The Older People Clinical Network developed, consulted and gained endorsement of:
- a description of an Area Geriatric Service
- the Acute Care of the Elderly Unit Model of Care
- the Geriatric Evaluation and Management Unit Model of Care
- the Community Geriatric Services Model of Care
- the Geriatric Consultation and Liaison Team Model of Care
- the SA Health Services Plan for People with Dementia (and Delirium) 2015-18.

1.2.1.6 Palliative care
The Palliative Care Clinical Network continued to work on the development of initiatives outlined in the Statewide Palliative Care Service Plan 2009-16 (the Plan). Key achievements include:
- Co-hosting a SA Palliative Care State Conference with Palliative Care SA, Older People Clinical Network and Renal Clinical Network in May 2015.
- Finalised and submitted a draft framework document which outlines the existing model of care for specialist palliative care services across the state.
- Members of the Research Collaborative developed a survey to seek General Practitioners views on the appropriateness and value of case conferencing in the palliative setting. The Network partnered with GP Partners Australia to disseminate the survey to GPs currently working within the state.
- Members of the Education Subcommittee completed an audit of palliative care education, training and learning opportunities within SA. This information formed the basis for a proposal document, submitted to the Network Steering Committee that highlighted current issues, gaps and key recommendations for consideration.
In collaboration with GP Partners Australia, facilitated the establishment of the Palliative GP Shared Care Program which provides GPs with a special interest with additional training to support the management of patients with a life limiting illness within the Community.

Established a new Consumer Survey Workgroup to develop a ‘proof of concept’ for a palliative care consumer experience survey within the Measuring Consumer Experience Safety Learning System (SLS) module.

In September 2014, the SA Ambulance Service (SAAS) collected data on Extended Care Paramedic (ECP) call outs to palliative patients. The Network compared the results with data collected for the same period in 2012 to review trends in utilisation and to determine whether patients were able to remain at their place of residence.

### 1.2.1.7 Rehabilitation

In 2014-15, the Rehabilitation Network key activities include:

- a Statewide Transition Coordinator commenced work in February 2015 on developing and facilitating 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 continued with health service representatives on the expert workgroup implementing service improvement initiatives. Interim findings show that these activities have assisted in decreasing average length of stay by approximately two days and an increasing in total referrals to rehabilitation by approximately 5%
- continued 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.
- work continued on the Clinical Pathway/Guideline and standardised data collection process – use of Botulinum Toxin. Spasticity clinics collected data and submitted them to the SA Medicines Evaluation Panel (SAMEP), according to the guideline and standardised process.

### 1.2.1.8 Renal

In 2014-15, the Renal Clinical Network worked on:

- the price per treatment model of funding for Haemodialysis treatments has been developed for implementation.
- in March 2014, Central and Northern Adelaide Renal and Renal Transplantation Service (CNARTS) commenced a pilot program utilising a Renal Supportive Care Nurse Practitioner based on the model of care from the August 2013 Renal Clinical Networks’ Renal Supportive Care Pathway paper. The pilot was deemed cost effective and a permanent position of a Renal Supportive Care Nurse Practitioner was approved and appointed in December 2014 within CNARTS. The Renal Clinical Network has continued to work on recommending that the model of care be replicated within Southern Adelaide Local Health Network.
- continued work on a model of care paper for Community Management of Chronic Kidney Disease.
- undertook for a trial patient experience survey (Statewide Renal KPI 8) of the patients attending the Renal Transplant Pre-Assessment Clinic. The patient experience survey was developed as part of the SA Health Safety and Quality pilot on Measuring Consumer Experience Safety Learning System module. Lessons learnt from the trial will be incorporated into a larger consumer experience survey of patients who attend for haemodialysis treatments.
- revised two Renal clinical guidelines.
  - Vancomycin Resistant Enterococci (VRE) and Methicillin-resistant Staphylococcus aureus (MRSA) Screening and Management in the Adult Renal Patient Population Clinical Guideline.
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1.2.1.9 Stroke

A forum was held in September 2014 to finalise the Stroke Management Procedures and Protocols. The forum began with a consumer interview about the care he had received both in and out of hospital. Presentations were given outlining the hyper-acute and acute pathways. Discussion then focused on prioritising key performance indicators to form the first set of indicators to be developed for monitoring and quality improvement activities. The final presentation was given by the National Stroke Foundation on work that is occurring nationally.

Following the forum, the Stroke Clinical Network developed a suite of processes to assist with the implementation of the Stroke Management Procedures and Protocols. The implementation package included:

- undertaking consumer experience surveys
- undertaking a gap analysis process – comparing current service provision with the Stroke Management Procedures and Protocols
- a case note audit.

The information gained from the implementation package was to be used to inform the development of an action plan, identifying actions and people responsible. Data to support the implementation process, particularly for key performance indicator reporting, has been incorporated into a new stroke package within the Local Health Network Analytics and Reporting System (LARS). The gap analysis process has been completed and will inform the Transforming Health Stroke Project.

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

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.

New Clinical Guidelines:
- SA Child Health Clinical Network – Paediatric Clinical Practice Guidelines
- SA Perinatal Practice Guidelines
- Infection Control Service

Revised Clinical Guidelines:
- SA Perinatal Practice Guidelines
- Infection Control Service
- Medicines and Technology Policy and Programs
- SA Neonatal Clinical Network - SA Neonatal Medication Guidelines

For a full list of the new and revised clinical guidelines, refer to appendix 1, on page 165.
1.2.3 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 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).

1.2.3.1 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 provide feedback and close the case or advise that the case undergo further analysis, ie 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 warrant further investigation

> a report could usefully 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.

1.2.3.2 Reduction in deficiencies of care

In surgery, there will always be some high-risk patients and procedures, with the result that some level of mortality is unavoidable. Identification of preventable factors should be the focus of efforts to reduce surgical mortality. Such data is collected by SAAPM in the form of serious clinical management issues where the assessor identifies areas of concern and/or adverse events. It is encouraging to note that the proportion of cases with such issues identified has decreased considerably since the commencement of the audit: in 2010-11, the proportion peaked at 16%, while the proportion has remained steady in recent years (7% in 2012-13, 8% in 2013-14). Initiatives are ongoing to further reduce cases with clinical management issues. Incidents at the preoperative stage are consistently the most commonly reported issues, particularly concerns about the decision to operate and delay in diagnosis. To address these issues, SAAPM (in collaboration with SA Health) presented a seminar in July 2015 entitled ‘The decision to operate – or not’ (see 1.2.3.3), and is preparing articles for publication on topics relating to preoperative care.
1.2.3.3 South Australian Audit of Perioperative Mortality (SAAPM) seminar: 'The decision to operate – or not'

Following the success of SAAPM’s first seminar held in February 2012 entitled ‘Recognising the deteriorating patient’, a second seminar was held in July 2015 entitled ‘The decision to operate – or not’.

The appropriateness of the decision to operate or not is a recurring issue that has been raised by assessors through the audit process. The issue applies to all specialties, and can refer to:

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

Speakers, including surgeons from various specialties and other clinicians, addressed these issues by reflecting on their experiences and the use of risk assessment tools.

The seminar was well attended by a range of health professionals, including surgeons, surgical trainees, anaesthetists and nurses. Of the respondents to a post seminar evaluation survey, 91% felt that they had gained valuable knowledge and skills, 74% of whom agreed that they would apply the knowledge and skills in their roles.

Comments included:
“All sessions were excellent and complemented each other (various opinions/perspectives).”
“I am often left dealing with the poor outcomes of surgery in elderly patients so found this very relevant to my work.”
“Fine discussion of intricate problem. This is a converted crowd, need to keep discussion going.”

1.2.3.4 Clinical management issues in preoperative care

Analysis of SAAPM data for the 2013-14 Annual Report found that, as in previous years, the majority of clinical management issues (ie preventable aspects of surgical mortality cases) occurred at the preoperative stage (34 preoperative issues were identified in 2013-14). Two aspects of preoperative care that were identified as requiring increased attention and awareness were:

1) delays relating to the diagnosis or treatment of Fournier gangrene or necrotising fasciitis, and
2) lack of appropriate services.

1.2.3.5 Fournier gangrene and necrotising fasciitis

It is apparent from a number of cases audited by SAAPM that the diagnosis of Fournier gangrene or necrotising fasciitis is not always made rapidly even when the clinical features are atypical for the original tentative diagnosis (such as urinary tract infection). It is suggested that all medical staff should be aware of the clinical features of necrotising fasciitis or Fournier gangrene and the need for early debridement.

1.2.3.6 Lack of appropriate services

Although the lack of services for treatment is not commonly identified as a factor contributing to surgical death, it has been identified as an important issue, particularly in the area of preoperative optimisation, given the increasing number of obese patients. In one case audited by SAAPM, a morbidly obese patient was advised to have a stomach banding procedure. The patient was also advised to go on a very low calorie diet but was unable or unwilling to do so. The operative procedure was difficult due to a very large fatty liver. Operative access difficulties resulted in a liver laceration (bleeding controlled). There was also postoperative airway obstruction. The assessors felt that preoperative optimisation may have lessened the risks of surgery, and suggested that a very low calorie diet (VLCD) would have decreased the liver size. It was noted that such services were not readily available.
1.2.3.7 New clinical governance report for hospitals

As well as educating and informing surgeons, SAAPM now provides annual reports to hospitals. The first clinical governance reports were provided to hospitals (those with a sufficient number of surgical deaths and surgeons to allow for de-identification) in March 2015, providing data to monitor trends in clinical indicators. These reports were developed with the Australian and New Zealand Audit of Surgical Mortality (ANZASM), in consultation with hospitals both within South Australia and nationally, and were distributed to hospitals nationally by each state’s respective audit office.

The report is currently being enhanced to incorporate feedback from hospitals and Health Departments, and the next version will have an increased focus on alignment with NSQHS Standards.

A copy of the South Australian Audit of Perioperative Mortality 2014 Annual report can be accessed on the Royal Australasian College of Surgeons website (www.surgeons.org)

1. Governance for Safety and Quality in health service organisations

1.2.4 Mental health

1.2.4.1 Strategic Mental Health Quality Improvement Committee

The Strategic Mental Health Quality Improvement Committee is responsible for the monitoring and improvement of safety and quality in mental health services across the state. The Committee reviews 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.

1.2.4.2 Pathways to care

SA Health began implementation of the Pathways to Care Policy Directive and Policy Guideline in May 2014. The policy describes best practice principles and service provision in mental health across eight areas, comprising: participation, access, care and treatment, transfer of care, working with other service providers, exiting, re-entry and transport. It includes eight reporting requirements to assist in both evaluating services and the policy implementation which are entered into the Safety Learning System Incident Management module. Fact sheets are available on the following eight reportable incidents:

- a refusal of a service to accept an allocated person into their service
- returning a person to the Emergency Department following refusal to accept the person
- the handover from the transferring service lacking information which is critical for ongoing care
- a person waiting for a bedded service longer than 24 hours in an emergency department or longer than 72 hours in the community
- all deaths that occur whilst a person is receiving care in Mental Health Service
- exit to homelessness
- acute medical deterioration in a Mental Health Unit requiring emergency response and/or transfer to a medical facility, and
- admission of a child under 18 years to a facility not specifically set aside for the treatment and care of individuals of that age group.

1.2.4.3 Incidents of restraint and seclusion in mental health services

Reports of the use of restraint have improved with increasing awareness of Safety Learning System (SLS) reporting requirements.

2014-15 data demonstrates the true prevalence of restraint and seclusion occurring in mental health services, following mandatory requirement to reporting which commenced in 2013-14.

Work is being undertaken to ensure that there is consistency in reporting, and a shared definition of what constitutes restraint. This includes adherence to the Department for Health and Ageing, Decision-making tool: supporting a restraint free environment in residential aged care, 2012.

Table 4: Restraint and seclusion in Mental Health Services

<table>
<thead>
<tr>
<th>Restraint and seclusion in Mental Health Services</th>
<th>2013-14</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restraint</td>
<td>1054</td>
<td>3925</td>
</tr>
<tr>
<td>Seclusion</td>
<td>531</td>
<td>580</td>
</tr>
<tr>
<td>Total</td>
<td>1585</td>
<td>4505</td>
</tr>
</tbody>
</table>

Source: Safety Learning System
Table 5 indicates that 80.6% of all restraint or seclusion is for less than eight hours.

**Table 5: Type and duration of restraint in Mental Health Services where duration known**

<table>
<thead>
<tr>
<th>Type</th>
<th>Less than 4 hours</th>
<th>Between 4 – 8 hours</th>
<th>Between 8 – 12 hours</th>
<th>Greater than 12 hours</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restraint</td>
<td>1001</td>
<td>2078</td>
<td>804</td>
<td>17</td>
<td>3900</td>
</tr>
<tr>
<td>Seclusion</td>
<td>421</td>
<td>78</td>
<td>18</td>
<td>24</td>
<td>541</td>
</tr>
<tr>
<td>Total</td>
<td>1422</td>
<td>2156</td>
<td>822</td>
<td>41</td>
<td>4441</td>
</tr>
</tbody>
</table>

| Total % | 32.0% | 48.5% | 18.5% | 0.9% | 100% |

Source: Safety Learning System

### 1.2.4.4 Seclusion and Restraint reduction initiatives

The Office of the Chief Psychiatrist (OCP) takes the lead role in the reduction of the use of restraint and seclusion of consumers in mental health settings through:

- facilitating the statewide Restraint and Seclusion Minimisation Working Group
- working with SA Health Safety and Quality Unit on the challenging behaviour policy, guideline, toolkit and online eLearning packages
- supporting and improving data collection and analysis across the state
- assisting individual units with service improvement and incident reviews; and

In July 2015, the Office of the Chief Psychiatrist will release the Restraint and Seclusion in Mental Health Services Policy Guideline, standards and toolkit, and will be available online.

Ongoing work includes involvement in the National Safety and Quality Partnerships Subcommittee (SQPS) to improve data collection on restraint incidents and development of a national definition for the use of parenteral medication that is often referred to as chemical restraint.

South Australia provides data for national reporting and currently has the second lowest rate of seclusion per 1000 bed days across Australia. Where seclusion is used, 78% has a reported duration of less than 4 hours.
Graph 2: Rate of seclusion events, Public Sector Acute Mental Health Hospital Services 2013-14

Source: Australian Institute of Health and Welfare – Admitted patient mental health-related care Table AD.16
Note: Data is the most recent available at the time of publication.

1.2.4.5 South Australian Suicide Prevention Strategy

The South Australian Suicide Prevention Strategy 2012-16: Every life is worth living (the Strategy) has progressed in its implementation. SA Government departments have worked with the OCP to create an inventory of their activity under the Strategy.

The Strategy calls for an all of community response to suicide prevention and establishment of Suicide Prevention Networks, which focus on awareness, breaking down stigma, bringing education to the community and supporting those bereaved by suicide.

Networks have been established in local government regions including Mount Gambier, Gawler, Murray Bridge, Clare and Gilbert Valley, Whyalla, and Playford, Naracoorte, Yorke Peninsular and Mid Murray. The South East Aboriginal Suicide Prevention Network is also based at Mount Gambier. Further networks established by Wesley Lifeforce are active in Strathalbyn, Port Adelaide and Port Augusta, Ceduna and West Torrens.

Over the next 12 months the South Australian Government Suicide Prevention Implementation Committee will oversee the development of a new draft South Australian Suicide Prevention Strategy.

1.2.4.6 Safety and quality initiatives

Initiatives completed during 2014-15 include the:

- release of the Electro-Convulsive Therapy Policy Guideline and Chief Psychiatrist Standard
- final draft of the Restraint and Seclusion in Mental Health Services Policy Guideline standards and toolkit
- further expansion of the Sexual Safety in Mental Health Services Policy Guideline
- Advance Care Directive implementation within mental health services
- piloting of the Framework for Mental Health in Multicultural Australia
- review of clozapine clinical guidelines and care plans; and
- online access of medication reconciliation information to reduce medication errors.
1.2.5 Perinatal Emergency Education Strategy

A review of obstetric cases across the health system identified that structured and standardised education for all staff involved in this area could improve outcomes and provide a happier, safer birthing experience for women and their partners. The areas identified as needing better education were in the management of obstetric emergencies, fetal surveillance, neonatal resuscitation and recognition of the deteriorating neonate with work on the deteriorating neonate being undertaken by the deteriorating patient working group. Current education programs and resources in place were audited initially to enable the strategy to build upon the work already in place and identify gaps to be addressed to ensure the successful implementation of the strategy. Part of this work included the purchase of additional equipment for all sites to enable them to deliver the programs.

With the assistance of the Perinatal Emergency Education Strategy Board consisting of representation from all Local Health Networks (LHN) providing obstetric and neonatal services and after consultation with relevant clinicians across the system the Perinatal Emergency Education Strategy Policy Directive has been developed which supports the Framework for Perinatal Emergency Education across SA. The policy directive describes the requirements for SA Health staff involved in the care of obstetric patients and neonates either in the home or in the acute care setting to complete some or all of the programs introduced under the Perinatal Emergency Education Strategy depending on their role and service level of the site in which they work. The strategy aims to provide standardised education across the state to:

- improve safety during childbirth and in the postnatal period providing a safer happier experience for women and their families
- improve communication between healthcare professionals and between them and their consumers
- increase educational capability across SA Health including rural sites
- provide a state wide coordinated approach to education.

In addition to metropolitan sites, eight educational hubs have been developed in Country Health SA Local Health Network to deliver training to all sites delivering level three to six obstetric services. The education hubs are situated in:

- Mount Gambier
- Murray Bridge
- Mount Barker
- Riverland
- Port Pirie
- Gawler
- Port Augusta
- Port Lincoln

All of these sites have staff trained to provide PRactical Obstetric Multi-Professional Training (PROMPT) and Neonatal Resuscitation Program (NRP) training and will host fetal surveillance study days.
1. Governance for Safety and Quality in health service organisations

Case study: Seclusion reduction project

Seclusion in mental health units is most commonly used to prevent the person from harming others, however it is well established that seclusion causes significant distress and trauma to the person who is secluded. Ward 5J at the Margaret Tobin Centre has been developing interventions to limit the use of seclusion both in the number of incidents and the duration of those incidents they were unable to avoid.

Initially a review of current practice was undertaken, including analysis of data, outstanding hazards and risks, ward culture, staff attitudes, skill mix, team dynamics and available consumer activities.

This was followed by the implementation of new strategies including; regular staff meetings; two day orientation to the unit; a mentoring and preceptor process; standardising clinical practice; reforming nursing teams to improve skill and gender mix; Non Violent Crisis Intervention® training for all staff; fortnightly seclusion and restraint review meetings; implementation of sensory modulation and a multi-disciplinary activity program. Consolidation and planning for future strategies occurred during 2014-15.

There was a 60% reduction in the number of seclusion incidents between the 2012-13 and 2013-14. Ward 5J was the winner of the ‘Improving Patient Safety’ award in the SA Health Awards 2014.

Graph 3: Total incidents of seclusion by month

Source: Safety Learning System

1.2.5.1 Establishment of standardised programs - PRactical Obstetric Multi-Professional Training (PROMPT)

PROMPT aims to improve communication and teamwork amongst all disciplines involved in the care of the obstetric patient in an emergency situation through team building and simulation exercises as well as skills sessions run by health professionals trained in PROMPT. Since February 2015, 68 staff from Northern Adelaide LHN, Southern Adelaide LHN, Women’s and Children’s Health Network and Country Health SA LHN including Obstetricians, Anaesthetists, General Practitioners and Midwives have been trained by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) to deliver PROMPT in their own site.

Since the introduction of PROMPT approximately 13% of staff across SA Health have been trained.
The picture below demonstrate a multi disciplinary team learning how to conduct PROMPT training back in their own unit with patient actors to authenticate the learning and provide feedback from a consumer perspective.

**Picture 8: A multi disciplinary team learning how to conduct PROMPT training**

The picture below demonstrates observers preparing to provide feedback on the team’s communication and teamwork in a safe, non threatening way using prompt sheets to direct the discussion.

**Picture 9: Observers preparing to provide feedback**
1. Governance for Safety and Quality in health service organisations

1.2.5.2 Fetal Surveillance Education Program (FSEP)
Since October 2014, SA Health has run 18 one day workshops led by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) which have been attended by over 300 staff. By providing this education we aim to reduce clinical intervention during childbirth and reduce incidences relating to neonatal resuscitation providing women with a positive birthing experience and be involved in decision making in partnership with their obstetric provider.

In addition to the study days, SA Health has purchased 1000 access logins to the RANZCOG online fetal surveillance program. Staff will alternate each year between attending a face to face study day and completing the online program. Both the study day and online programs include assessments which assist staff in their ongoing learning and development and will provide ongoing quality assurance to SA Health of the benefit of these programs.

Picture 10: Online Fetal Surveillance Education Program (FSEP+) screen shot

1.2.5.3 Neonatal Resuscitation Program (NRP)
A review of the online Neonatal Resuscitation Program and increase of trainers in rural centres will ensure that there are staff trained to care for neonates in the first few minutes of life as they transition from being in the uterus to taking their first breath. The Perinatal Emergency Education Strategy is also committed to ensuring that each centre has at least one clinician either on site or in close proximity who can deliver advanced neonatal life support.
1.2.5.4 Education and Training completed courses

Graph 4 demonstrates the percentage of clinicians required to perform training who have completed courses in PROMPT, FSEP and NRP between October 2014 and June 2015 (n = 1400).

Graph 4: Percentage of clinicians required to perform training who have completed the programs Oct 2014 - Jun 2015

Source: Perinatal Emergency Education database
1. Governance for Safety and Quality in health service organisations

1.2.5.5 Ongoing evaluation

Staff are generally required to complete the programs every two years and individual sites will be able to view their own staff progress via a Learner Management System which is currently in development. The Local Health Network Analytics and Reporting Service (LARS) will provide sites with a dashboard of their progress against other sites with patient outcomes also being monitored against the introduction of the programs.


References


2. RANZCOG Online Fetal Surveillance Education Program OFSEP

1.3 Credentialling

1.3.1 Program element

SA Health is committed to providing safe health care by credentialling health practitioners and defining the scope of clinical services to be delivered in a specific health care setting.

Credentialling is the process of verifying qualifications, experience and other relevant professional attributes for the purpose of forming a view about a health practitioner’s competence to deliver health care. This process assists Local Health Network's (LHN) to meet National Safety and Quality in Health Service Standard 1, criteria 1.10 - ‘implementing a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce’.

The Safety and Quality Unit provides system administration of the Credentialling and Scope of Clinical Practice System (CSCPS) database. The Office for Professional Leadership provides policy direction and communicates with the directors of each professional stream that needs to be credentialled. Clinical governance in each LHN is overseen by credentialling committees and key contacts. Once a credentialling committee has approved a health practitioner’s credentials, they are mutually recognised across SA Health. A scope of clinical practice needs to be defined and approved by each LHN credentialling committee for each LHN facility in which the health practitioner works.

Credentialling information is recorded in the CSCPS database for all medical, dental, allied and scientific health, nurse practitioners and independent midwives working in SA Health facilities. The CSCPS database is web accessible and available from all SA Health work stations 24 hours/seven days a week.

Table 6: Number of health practitioners, by professional groups, with credentials as at June 2015

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical practitioners</td>
<td>4733</td>
</tr>
<tr>
<td>Dental practitioners</td>
<td>515</td>
</tr>
<tr>
<td>Allied and scientific health practitioners</td>
<td>2933</td>
</tr>
<tr>
<td>Nurse practitioners</td>
<td>34</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8215</strong></td>
</tr>
</tbody>
</table>

Source: CSCPS

Table 7: Number of SA Health users in each CSCPS access category as at June 2015

<table>
<thead>
<tr>
<th>Access Level</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited view</td>
<td>View credentialling duration and scope of clinical practice</td>
<td>227</td>
</tr>
<tr>
<td>Head of unit</td>
<td>Enter and edit records for allocated professions and committees. Access is to specific health units within an LHN.</td>
<td>67</td>
</tr>
<tr>
<td>Credentialling officer</td>
<td>Enter and edit records for allocated professions and committees. Access is across the LHN.</td>
<td>188</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>482</strong></td>
</tr>
</tbody>
</table>

Source: CSCPS

SA Health staff can log on to CSCPS to see if a health practitioner has current credentials and a scope of clinical practice. Each credentialling committee has nominated users, with an additional level of access to CSCPS, who can view more detailed information for the purposes of auditing and preparing for accreditation.
1.3.2 Program achievements

Work has commenced to link data from CSCPS with data from the LHN Analytics and Reporting Service (LARS), in order to report on the following key performance indicators:

- percentage of medical and dental practitioners who are credentialled
- percentage of medical and dental practitioners who have a scope of practice
- percentage of medical and dental practitioners who are re-credentialled by their due date.

The process of sourcing and uploading relevant SA Health human resources information from the Complete Human Resources Information System (CHRIS) database into CSCPS has been reviewed. Some of the information recorded in CHRIS is the same as information required for credentialling and re-credentialling a health practitioner. A reliable and secure method of importing and matching CHRIS data in the CSCPS database may reduce data duplication and assist credentialling committees in completing the process.

Health practitioner registration renewal is directly sourced from Australian Health Practitioner Regulation Agency (AHPRA), using the multiple registration service, to identify practitioners with lapsed registration and/or registration conditions, endorsements or notations. This information can be imported to automatically update CSCPS.

Initiatives such as Transforming Health that result in changes to the organisational structure of SA Health, will be updated in CSCPS to ensure all credentialled health practitioners have a scope of practice assigned to the health division or service unit in which they provide clinical services.

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

Additional information is also available on the Australian Commission on Safety and Quality in Health Care website Credentialling for Health Professionals page at www.safetyandquality.gov.au/our-work/credentialling
1.4 Incidents and feedback (complaints) management

1.4.1 Safety Learning System (SLS)

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 12: Safety Learning System screen shot

1.4.2 Incident management

Between 1 July 2014 and 30 June 2015, 53692 incidents were reported into the Safety Learning System, a 21.7% increase from 2013-14 (n=9589) and a 42.5% (n=16010) increase from 2012-13.

It should be noted that the proportion of near-miss incidents reported during this period has increased. Increasing incidents reported and decreasing harm can be interpreted as a good reporting culture with the successful implementation of strategies.

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 8: Number of incidents reported by year by Level 1 Classifications 2012-15

<table>
<thead>
<tr>
<th>Primary Incident Classification</th>
<th>2012-13</th>
<th>2013-14</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient falls and other Injuries</td>
<td>10056</td>
<td>11527</td>
<td>12245</td>
</tr>
<tr>
<td>Medication</td>
<td>7631</td>
<td>9580</td>
<td>12054</td>
</tr>
<tr>
<td>Implementation of care</td>
<td>4380</td>
<td>3773</td>
<td>3780</td>
</tr>
<tr>
<td>Challenging behaviour</td>
<td>4257</td>
<td>2909</td>
<td>3903</td>
</tr>
<tr>
<td>Treatment, procedure</td>
<td>2659</td>
<td>2681</td>
<td>2504</td>
</tr>
<tr>
<td>Access, appointment, admission, transfer, discharge</td>
<td>2315</td>
<td>2402</td>
<td>2948</td>
</tr>
<tr>
<td>Clinical assessment</td>
<td>2144</td>
<td>2198</td>
<td>2227</td>
</tr>
<tr>
<td>Patient information</td>
<td>1215</td>
<td>1516</td>
<td>1772</td>
</tr>
<tr>
<td>Communication and teamwork</td>
<td>1010</td>
<td>1895</td>
<td>2200</td>
</tr>
<tr>
<td>Medical device/equipment</td>
<td>752</td>
<td>1227</td>
<td>1470</td>
</tr>
<tr>
<td>Staffing, facilities, environment</td>
<td>610</td>
<td>1071</td>
<td>1175</td>
</tr>
<tr>
<td>Pressure injury/ulcer/sore</td>
<td>461</td>
<td>1332</td>
<td>2380</td>
</tr>
<tr>
<td>Restraint/seclusion</td>
<td>30</td>
<td>1846</td>
<td>4780</td>
</tr>
<tr>
<td>Labour or delivery</td>
<td>162</td>
<td>146</td>
<td>198</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37682</strong></td>
<td><strong>44103</strong></td>
<td><strong>53692</strong></td>
</tr>
</tbody>
</table>

Source: Safety Learning System

Additional data relating to falls, medication, pressure injury, clinical deterioration and challenging behaviour is included in the relevant sections in this report.
The Safety Assessment Code (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 table 9.

### Table 9: Actual SAC rating as a percentage of the total incidents reported 2012-15

<table>
<thead>
<tr>
<th>SAC rating</th>
<th>% of total Incidents reported</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012-13</td>
</tr>
<tr>
<td>SAC 1</td>
<td>0.3%</td>
</tr>
<tr>
<td>SAC 2</td>
<td>1.3%</td>
</tr>
<tr>
<td>SAC 3</td>
<td>43.6%</td>
</tr>
<tr>
<td>SAC 4</td>
<td>52.2%</td>
</tr>
<tr>
<td>Uncoded incidents</td>
<td>2.7%</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 2014-15, the total number of sentinel event notifications increased from 2013-14 by 1 but decreased from 2012-13 by 2. Table 10 demonstrates the sentinel events that have occurred in the last three years.

### Table 10: Number of sentinel events reported by year by category 2012-15

<table>
<thead>
<tr>
<th>National sentinel event categories</th>
<th>2012-13</th>
<th>2013-14</th>
<th>2014-15</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>3</td>
<td>2</td>
</tr>
<tr>
<td>Retained instruments / other material after surgery requiring re-operation or further surgical procedure</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Intravascular gas embolism resulting in death or neurological damage</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Haemolytic blood transfusion reaction resulting from ABO (blood type) incompatibility</td>
<td>1</td>
<td>0</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>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Maternal death associated with pregnancy, birth and the puerperium</td>
<td>2</td>
<td>0</td>
<td>0</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>9</strong></td>
<td><strong>6</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>

Source: Safety Learning System
1.4.3.1 Change to the national sentinel event definition
In 2014-15 there was a change to the national sentinel event definition from ‘Maternal death or serious morbidity associated with labour or delivery’ to ‘Maternal death associated with pregnancy, birth and the puerperium’. This was accompanied by the development of the Severe Acute Maternal Morbidity (SAMM) national indicator set (18 indicators), to provide definitions that were consistent across jurisdictions and ensure that important data about serious morbidity was not lost.

The change was made at the recommendation of the Australian Commission on Safety and Quality in Health Care’s maternal sentinel event and post-partum haemorrhage working group, to assist in overcoming inconsistencies with the interpretation across jurisdictions of the original sentinel event category.

The new sentinel event definition has been applied retrospectively to the sentinel event data contained in this report.

1.4.3.2 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 2014-15, 28.57% (n=2) were suicides of patients in an in-patient unit. This is a reduction of one from 2013-14.

1.4.3.3 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 2014-15, 57.1% (n=4) of all sentinel events reported were in this category. This is a significant increase from previous years. However three were attributable to the failure of a medical device.

The medical devices involved:

> Surgical pack on investigation was left in situ prior to the first surgical count being complete. This was a break in protocol lead to the pack being retained. Processes have again been reinforced that the first count must be completed prior to wound closure commencement.

> A guidewire from a Central Venous Line was inserted with 5cm of the wire snapping off and unable to be retrieved. To prevent occurrence there has been revision of the documentation in which the surgeon must state that the guidewire has been removed in total.

> The retention of the drill bit was successfully removed in another procedure. A report was made to the Therapeutic Goods Administration (TGA) around a batch of faulty routers.

> The cutting balloon became detached from its shaft; this is a known risk of endovascular procedure. The company representative was present at time of incident and this case was reported to the TGA.

1.4.3.4 Medication error leading to the death of a patient as a result of incorrect administration of drugs
There was one sentinel event reported in this category, this number remains unchanged from 2013-14.

On review of this incident there has been comprehensive education undertaken to prevent this incident from occurring again, the use of this particular medication was new to this group of clinicians.
1.4.4 Open disclosure

Open disclosure is the open discussion of an incident that resulted in harm to a patient while they were receiving health care with that patient and their support persons.

The **SA Health Open Disclosure Policy Directive** was originally released in October 2011 to establish a consistent approach across the public health sector is currently being updated to ensure it aligns with the National Open Disclosure Framework.

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 2014-15, an open disclosure question was answered for 99.6% of all incidents reported.

Answers indicated that 58.2% of incidents had been disclosed by the notifier, manager or both, a 0.1% increase from 2013-14 (58.1%). These open disclosures were related to the following primary incident classification types.

### Table 12: Number and percentage of open disclosures made by primary incident classification 2013-15

<table>
<thead>
<tr>
<th>Primary incident classification</th>
<th>% of incidents disclosed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013-14</td>
</tr>
<tr>
<td>Patient falls and other injuries</td>
<td>77.7%</td>
</tr>
<tr>
<td>Medication</td>
<td>46.6%</td>
</tr>
<tr>
<td>Restraint/seclusion</td>
<td>63.5%</td>
</tr>
<tr>
<td>Challenging behaviour</td>
<td>63.0%</td>
</tr>
<tr>
<td>Implementation of care</td>
<td>53.6%</td>
</tr>
<tr>
<td>Pressure injury/ulcer/sore</td>
<td>75.5%</td>
</tr>
<tr>
<td>Access, appointment, admission, transfer, discharge</td>
<td>53.7%</td>
</tr>
<tr>
<td>Treatment, procedure</td>
<td>57.4%</td>
</tr>
<tr>
<td>Communication and teamwork</td>
<td>43.7%</td>
</tr>
<tr>
<td>Clinical assessment</td>
<td>38.7%</td>
</tr>
<tr>
<td>Patient information</td>
<td>32.1%</td>
</tr>
<tr>
<td>Medical device/equipment</td>
<td>47.0%</td>
</tr>
<tr>
<td>Staffing, facilities, environment</td>
<td>46.6%</td>
</tr>
<tr>
<td>Labour and delivery</td>
<td>87.7%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

1.4.5 Coronal 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 2014-15, the Coroner held 12 inquests relevant to the health portfolio that resulted in 23 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 2014-15.

1.4.5.1 Induction of Labour and Hypoxic Ischaemic Encephalopathy

Two separate inquests were held into deaths involving the induction of labour and resulting from hypoxic ischaemic encephalopathy. In the first of these cases, the Coroner concluded that the death could have been avoided if prostaglandin gels to induce labour had not been used, which could have been avoided if the babies’ mother had instead undergone delivery by way of elective caesarean section. In the second case, the Coroner concluded that the babies’ chances of survival would have been enhanced if the babies’ mother had been advised to present for induction of labour at a better resourced hospital.

The two inquests resulted in nine recommendations, which included:

> clinical guidelines be developed relating to the risk of uterine rupture occasioned by the administration of prostaglandin gel in a women who has had a previous uterine perforation whether surgically repaired or not.

> medical practitioners be advised that in the case of a uterine perforation that has not required surgical repair, there is a need to explain to the patient any risks associated with that rupture and any possible future consequences resulting from it

> given the potential catastrophic outcomes in cases of severe birth hypoxia, medical practitioners should candidly discuss these risks with their patients at an early stage of pregnancy to enable them to make an informed decision about which tier level hospital they will be admitted to for delivery.

> Consideration should be given to improving the way Cardiotocography (CTG) recordings are transmitted to obstetricians who are supervising labour from outside the hospital.

Key actions taken in response to the recommendations include:

> the South Australian Perinatal Practice Guidelines (SAPPG) – Induction of Labour Techniques was reviewed and changes were approved by the SA Maternal and Neonatal Clinical Network and then the SA Health Safety and Quality Strategic Governance Committee in December 2014. The guidelines apply to all Local Health Networks (LHNs) and advise that women with a uterine scar should be counselled that the use of prostaglandin is associated with increased risks, e.g. uterine rupture, severe haemorrhage, bladder laceration, hysterectomy, and may cause significant neonatal neurological morbidity or death. The SAPPG – Uterine Rupture are also planned to be reviewed and updated in consideration of the Coroner’s recommendations.

> SA Health wrote to all LHNs and requested that they bring the issue of uterine perforation to the attention of medical practitioners within their respective networks. In addition, the recommendations were discussed and information disseminated at various local forums, including high risk pregnancy, safety and quality, and adverse events committee meetings.
the SA Health Standards for Maternal and Neonatal Services in South Australia outline the minimum standards for each of the six recognised levels of perinatal care. Each health unit providing maternity and neonatal services has specific procedures and protocols designed to meet the needs of the local community. A set of criteria of assessing the risk profile of different pregnancies and the corresponding tier level at which services should be provided is presented in the standards. The early identification of these factors, timely referral, assessment and provision of appropriate care is critical in promoting good outcomes for patients and their infants, as well as the efficient use of health resources.

The SAPPG – Cardiotocography has been reviewed and final amendments are currently being drafted for approval by the SA Maternal and Neonatal Clinical Network and then the SA Health Safety and Quality Strategic Governance Committee.

1.4.5.2 Sudden unexplained infant death
An inquest was held into a death that involved a sleeping environment which carried an intrinsic risk of sudden unexplained infant death.

The inquest resulted in 10 recommendations, which included:

- as part of any Child and Family Health Service (CaFHS) home visit assessment of an infant’s circumstances, CaFHS nurses and other workers should thoroughly investigate and document the sleeping environment of an infant within the infant’s home and that such investigation and documentation should take place on every home visit.
- as part of any CaFHS home visit assessment of an infant’s circumstances, CaFHS nurses and other workers should give appropriate consideration as to whether or not a parent or parents of an infant might require assessment or care in relation to the mental health of that parent or parents and to recommend the appropriate services that might provide the same.

Key actions taken in response to the Coronial recommendations include:

- since this death there have been several developments in the way that CaFHS home visit assessments are undertaken. The Universal Contact Visit (UCV) incorporates the recommendations of the Safe Sleep Standards developed by the SA Health Safe Sleeping Advisory Group. These are discussed with the infant’s caregiver and documented at the one to four week health check. The sleeping environment of the baby is also assessed at every home visit.
- all CaFHS nursing and allied health staff are trained in the use of screening tools and determining the most appropriate service response and referral pathway. Improved processes have also been implemented to support the transfer of information from the birthing hospitals to CaFHS. If the birthing hospital has concerns about the mother’s wellbeing or if there is information that is required to assist CaFHS nurses in working with the family, a Priority Information Form (PIF) can be completed and sent to CaFHS.
1.4.5.3 Transportation of mentally ill patients in rural SA

An inquest was held into the death of a person subject to a Guardianship Board order where the Coroner highlighted issues relating to the transportation of mentally ill patients in rural SA.

The inquest resulted in two recommendations, which included:

> there should be ongoing awareness by Rural and Remote Consultants of the need to assess carefully risk/safety factors and the limitations of rural hospitals in managing acutely psychotic and violent patients in rural SA

> that in according priority to the transportation of mentally ill patients, that priority be given, where possible, to the transport of patients who are the subject of inpatient treatment orders under the Mental Health Act 2009 or who are the subject of other measures that have been invoked under that Act.

Key actions taken in response to the Coronerial recommendations include:

> All consultant psychiatrists and rural and remote staff were advised of the Coroner’s recommendations at the Transport Working Group, comprised of representatives from MedSTAR, Royal Flying Doctor Services (RFDS), South Australian Ambulance Service (SAAS) and Country Health SA Local Health Network (CHSALHN).

> The Rural and Remote Emergency Triage and Liaison Service provides advice and services seven days a week, 24 hours a day and includes access to an on-call psychiatrist.

> The third edition of the Transportation of Mental Health Patients from Country South Australia to Metropolitan Services is currently in draft revision. This edition reflects the Coroner’s recommendations and includes sedation protocols for providing advice to local hospitals. The sedation protocols were endorsed by the Statewide Mental Health Clinical Network.

> All rural mental patient transport requests are centrally assessed in the SAAS Emergency Operations Centre and awarded an appropriate priority after consultation with Rural and Remote Mental Health. Priority coding is provided to the RFDS at the time a request for transport is made and the patient transfer is conducted to an agreed response time.
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.

1.4.6.1 Type and method of consumer feedback

Between 1 July 2014 and 30 June 2015, 11051 records of consumer feedback were reported into the Safety Learning System Consumer Feedback module, a 17% increase from 2013-14 (n=9432).

Between 2014-15 and 2013-14, there has been a 78% increase in the number of suggestions received, a 22% increase in the number of compliments, and 14% increase in the number of complaints received.

Graph 5: SA Health consumer feedback received by type and method of feedback 2014-15

Source: Safety Learning System
1.4.6.2 *Classification of complaints by national health complaint categories*

Between 2014-15 and 2013-14, there has been a 0.6% increase in the number of complaints in relation to communication from 27.6% to 27.0%, a 0.7% increase in complaints received on treatment, and a 1.8% decrease in relation to access from 23.1% to 21.3%.

**Graph 6: Classification of complaints by national health complaints categories 2013-15**

<table>
<thead>
<tr>
<th>National health complaint categories</th>
<th>2013-14</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Grievances</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Professional conduct</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Privacy/discrimination</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Corporate services</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>Cost</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Access</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Treatment</td>
<td>27%</td>
<td>27%</td>
</tr>
<tr>
<td>Communication</td>
<td>28%</td>
<td>28%</td>
</tr>
<tr>
<td>Cost</td>
<td>5%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System
### 1.4.6.3 Strategies for improvement

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 2014-15 the Safety and Quality Unit continued to work on areas of improvement in relation to consumer feedback including the development of the Partnering with Consumers online eLearning course, and suite of standardised consumer feedback reports.

Data from the SLS Consumer Feedback module is 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 within 2 working days
- Complaints resolved and closed less than 35 working days.

The review of the SA Health Consumer Feedback and Management Policy Guideline and Toolkit will be a focus in 2015-16.


### 1.4.6.4 Consumer feedback in Measuring Consumer Experience Report

The fourth Measuring Consumer Experience Report includes data gathered through SA Consumer Experience Surveillance System (SACCESS) between 1 January to 31 December 2014 (n=2316).

SA Health gathers feedback by surveying people who have spent time in a country or city public hospital. The telephone survey collections information on all aspects of a person's stay, from their involvement in decision-making, care and treatment, privacy and pain control to hospital cleanliness, food quality and discharge information.

Questions are also asked and analysed across five additional areas, including consumer feedback, emergency department, workforce, hand hygiene and cleanliness – facilities.

Consumer feedback with a low average score of 41.8 (se 0.5, 95% CI 40.9-42.7), is well below the SA benchmark of 85, with all areas below the benchmark requiring immediate action. Scores were derived from responses following survey questions in relation to consumer feedback.

Analysis of these results indicates that during their stay in hospital, patients were not asked to give their views on the quality of care they received.
Table 13: Consumer feedback questions, SA overall, SACESS 2013 and 2014

<table>
<thead>
<tr>
<th>Consumer feedback and actual questions</th>
<th>Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
</tr>
<tr>
<td>During your hospital stay, were you ever asked to give your views on the quality of your care?</td>
<td>7.7</td>
</tr>
<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>31.1</td>
</tr>
<tr>
<td>Did you want to complain about the care you received in hospital?</td>
<td>91.5*</td>
</tr>
<tr>
<td>Prior to receiving our letter, did you know that there is a Public Patients Charter listing your rights?</td>
<td>31.0</td>
</tr>
</tbody>
</table>

Source: SA Consumer Experience Surveillance System (SACESS)

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

To improve the consumer feedback category, SA Health is developing a Consumer Awareness program informing people how to give feedback both during and after their hospital stay, and understanding their rights.

In October 2014, the SACESS questionnaire was reviewed including the consumer feedback and patient rights and engagement questions. The amended questionnaire commenced with interviews from January 2015. The revised questions for these areas include:

**Consumer feedback:**

> How comfortable did you feel that you could make a complaint or a suggestion, or raise a concern with staff?
> Did you see or were you given any information explaining how to complain to the hospital about the care you received?
> During this hospital stay, how often was it easy for you to find someone on the hospital staff to talk to about your concerns?

**Patient rights and engagement:**

> Do you know your rights as a patient?
> Were you provided information on your rights as a patient?
> Did staff explain your rights as a patient to you?
> Could you understand the patient rights that had been explained to you?

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

1.5.1 Charter of Health and Community Services Rights Policy

The SA Health Charter of Health and Community Services Rights Policy Directive implements the Charter of Health and Community Services Rights (the HCSCC Charter), 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 are aligned to the national health complaint category and sub category in the Safety Learning System Consumer Feedback module.

Graph 7 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 2013-14.

Between 2014-15 and 2013-14, there has been a 3% increase in the number of complaints reported which align to the Charter of Rights in relation to quality from 38% to 41%. Complaints in relation to access are 22.6%, there has been a 1% decrease in relation to information.

Graph 7: SA Health complaints aligned to HCSCC Charter 2013-15

Source: Safety Learning System
Table 14 demonstrates the national health complaints categories and subcategories aligned to the HCSCC Charter of Rights.

### Table 14: National health complaints categories 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><strong>Access</strong></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><strong>Communication</strong></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><strong>Consent</strong></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><strong>Corporate Services</strong></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><strong>Cost</strong></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><strong>Grievances</strong></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><strong>Privacy / discrimination</strong></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><strong>Professional conduct</strong></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><strong>Treatment</strong></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

### 1.5.2 Translated Charter of Rights consumer information sheets

In March 2015, a number of Health and Community Services Complaints Commissioner (HCSCC) Charter of Rights Consumer Information Sheets were translated into 12 languages, in addition to the existing 14 publications.

Table 15: Translated Charter of Rights Consumer Information Sheets

<table>
<thead>
<tr>
<th>New publications</th>
<th>Existing publications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulgarian</td>
<td>Arabic</td>
</tr>
<tr>
<td>Macedonian</td>
<td>Indonesian</td>
</tr>
<tr>
<td>Dari</td>
<td>Chinese simplified</td>
</tr>
<tr>
<td>Russian</td>
<td>Italian</td>
</tr>
<tr>
<td>Macedonian</td>
<td>Dari</td>
</tr>
<tr>
<td>Tamil</td>
<td>Croatian</td>
</tr>
<tr>
<td>Indoneisan</td>
<td>Hungarian</td>
</tr>
<tr>
<td>Polish</td>
<td>Hindi</td>
</tr>
<tr>
<td>Nepali</td>
<td>German</td>
</tr>
<tr>
<td>English</td>
<td>Dari</td>
</tr>
<tr>
<td>Dinka</td>
<td>Greek</td>
</tr>
<tr>
<td>Serbian</td>
<td>Greek</td>
</tr>
<tr>
<td>Australian</td>
<td>Dari</td>
</tr>
<tr>
<td>Commission</td>
<td>Hungarian</td>
</tr>
<tr>
<td>Charter of</td>
<td>Dari</td>
</tr>
<tr>
<td>Healthcare</td>
<td>Hungarian</td>
</tr>
<tr>
<td>Rights</td>
<td>Dari</td>
</tr>
<tr>
<td>Information</td>
<td>Hungarian</td>
</tr>
<tr>
<td>sheets</td>
<td>Dari</td>
</tr>
</tbody>
</table>

Item 2: Dari Charter of Rights Consumer

Item 3: Punjabi Charter of Rights Information Sheet

Consumer Info Sheet

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


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 frameworks⁴.

National Safety and Quality Health Service (NSQHS) Standard 2 – Partnering with Consumers includes consumer partnership in service planning, designing care, service measurement and evaluation.

2.1 Consumer partnerships in service planning

2.1.1 SA Health Partnering with Consumers and the Community Advisory Group

The SA Health Partnering with Consumers and the Community Advisory Group (PwC&CAG) was established in 2013, and is the strategic committee for Partnering with Consumers. Work is underpinned by:

> the Australian Safety and Quality Framework in Health Care
> NSQHS Standard 1 - Governance for Safety and Quality in health service organisations in relation to complaints management, patient rights and engagement and open disclosure
> NSQHS Standard 2 - Partnering with Consumers
> Australian Safety and Quality Goals for Health Care Goal 3 – Partnering with Consumers.

Representation on the Advisory Group includes Health Consumers Alliance SA, Health and Community Services Complaints Commissioner, Consumers, Local Health Networks, including Drug and Alcohol Service, SA Ambulance Service, SA Health including; Mental Health and Substance Abuse, Nursing and Midwifery Office, Service Development, Safety and Quality Unit.

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 (the Framework) and A Guide for engaging with Consumers and the Community (the Guide).

A ‘spotlight’ schedule has been developed, where PwC&CAG Local Health Network representatives are invited to showcase how they engage with their local consumers and community in addressing Standard 2 Partnering with Consumers.

In 2014-15, the SA Health Partnering with Consumers and Community Strategic Action Plan continues work on addressing:

> measuring consumer experience (see page 74)
> partnering with consumers online eLearning course
> data reporting and monitoring

⁴ National Safety and Quality Health Service Standards (September 2011), Australian Commission on Safety and Quality in Health Care
Sub groups of the SA Health Partnering with Consumers and Community Advisory Group were convened and the following policies, guidelines and toolkits were developed including the:

- Partnering with Carers Policy Directive
- Sitting Fees and Reimbursement for External Individuals Policy Directive
- Consumer and Community Advisory Committee/Group (CACAC/CAG) Guideline and Toolkit (see page 69)
- These policies, guidelines and toolkit which will be released in late 2015.

2.1.1.1 Partnering with Carers

In 2014-15 a sub group of the SA Health Partnering with Consumers and the Community Advisory Group was established with members of Health Consumers Alliance SA, Carers SA, and SA Health Service Development, and Safety and Quality Unit.

Through the Carers Recognition Act 2005 the South Australian Government has recognised the roles and rights of carers. SA Health is seeking to build on this recognition through a commitment to ensuring better carer engagement in health care decisions.

SA Health worked with Carers SA and Health Consumers Alliance to develop a new policy directive for carers in the health system. Policy development has included research, analysis of legislation, strategic alignment with existing policies, stakeholder meetings and broad consultation with carers. The new policy replaces the 2010 Carers Participation Position Statement Guideline.

A range of consultative methods were undertaken in developing the policy, including social media, and a World Café event - SA Health Carers Engagement Forum which was held on 30 September 2014. The forum brought together carers from across South Australia to gather input on their priorities and what was important to them. Participants were invited to provide feedback on:

- their experience as a carer in the health system
- how the public health system can support carers
- identifying what opportunities exist for carers to the health outcomes of those they care for
- increasing awareness and recognition of the different roles of carers.

Picture 13: Participants at the SA Health Carers Engagement Forum World Café Event

A formal public consultation period was held from 18 February to 24 March 2015. Local Health Networks were invited to provide feedback on the draft policy. Carers SA and the other carers associations that form the SA Carers Network were also invited to contribute to the consultation. 21 responses were received and this feedback has been incorporated into the final policy directive.
2. Partnering with consumers

The new SA Health Partnering with Carers Policy Directive key features include:

- clearly defined purpose to recognise and support carers and their roles specifically with regard to how carers interact with the South Australian public health system
- principles and Standards for SA Health in partnering with carers that identify the priorities for carers, based on feedback from carers
- clearly defined roles and responsibilities for SA Health employees
- greater alignment with the Carers Recognition Act 2005 and the existing suite of consumer engagement policies including SA Health A Framework for Active Partnership with Consumers and the Community
- recognition of the role of partnering with carers in meeting the National Safety and Quality Health Service Standards 1 and 2.

The SA Health Partnering with Cares Policy Directive is due to be released in late 2015.

Further information is available on the Safety and Quality section of the SA Health website Partnering with carers page at www.sahealth.sa.gov.au/safetyandquality.
2.1.1.2 Culturally and Linguistically Diverse (CALD) consumer experience

Health literacy plays an important role in enabling effective partnerships. The health service is responsible for making it as easy as possible for patients, consumers, families and carers to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate actions.

The SA Health Safety and Quality in Health Care Consumer and Community Advisory Committee (CACAC) and Culturally and Linguistically Diverse (CALD) Consumer Experience Advisory Group, with representation from Multicultural Communities Council SA and Seniors Information Service have developed a number of resources.

In 2014-15, CALD resources were developed to ensure that the patients/consumers who do not speak English or who have a low level of English proficiency are respected, and that their preferences and expressed needs will be met. The resources include an interpreter card and posters, which will assist by:

- making it easier for patients/consumers to request an interpreter
- helping staff when arranging an interpreter for the patient/consumer, to ensure that the interpreter is provided in their preferred language and dialect.

The local health networks will pilot the CALD resources in outpatient departments or community settings in 2015-16. An evaluation will be undertaken by the SA Health Partnering with Consumers and Community Advisory Group following the pilot.

**Item 4: Interpreter card**

The interpreter card is available as a wallet/business card size or post card size.

![Interpreter card image]

**My preferred language and/or dialect is:**

**Item 5: National interpreter symbol poster**

The national interpreter symbol provides a simple way of indicating where people with limited English proficiency can ask for language assistance when using government services.
2. Partnering with consumers

Item 6: Do you need an interpreter? poster

The Do you need an INTERPRETER? poster displays country flags and languages and asks patients/consumers to:

“Please indicate which language you speak and we will arrange an interpreter for you.”

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For more information

SA Health
Safety and Quality Unit
11 Hindmarsh Square
Adelaide SA 5000
Telephone: 08 8225 9533

List of flags based on the top 25 communities that accessed SA Health in 2013-14.

Endorsed by ISOCAG for consumers and the community.

Government of South Australia
SA Health
The poster was developed in partnership with the Interpreting and Translating Centre, Department of Communities and Social Inclusion, SA and the content is adapted for use with their permission.

The list of flags is based on the top (20) communities who accessed SA Health in 2013-14.

An audit tool has also been developed to monitor the usage and effectiveness of the resources being trialled.

Further information is available on the Safety and Quality section of the SA Health website Partnering with culturally and linguistically diverse consumers page at www.sahealth.sa.gov.au/safetyandquality.
2. Partnering with consumers

Case study:

Culturally and Linguistically Diverse (CALD) community consumer experience forum: Vietnamese Women’s Association

The CALD community consumer experience forums were established in 2013 as an opportunity for SA Health to better understand the cultural and linguistically diverse (CALD) community needs in health care.

CALD consumers are given an opportunity to share their experiences and their perspective on how health care is received and they are asked what we can do to improve health care services.

Previous CALD community consumer experience forums have been held with the Italian Benevolent Foundation (IBF) Italian Southern Carers Group, and the Greek Orthodox Community of SA (GOCSA) Limani Dementia Respite Program.

Vietnamese Women’s Association

In November 2014, the Safety and Quality Unit met with the Vietnamese Women’s Association.

The forum attendees included nine carers and two bilingual workers, who assisted in enabling a conversation to occur. Consumers share their experience on care and treatment, access to interpreter, cultural needs, physical and environmental needs, what was required when leaving hospital, and providing consumer feedback.

Picture 14: Vietnamese Women’s Association participants at the community forum.

The Vietnamese Women’s Association (WVA) provides family support, Home and Community Care (HACC) and Carer support. VWA assist, provide information and referral matters that relate to the resettlement.

They also provide opportunities to share skills and knowledge in cross cultural parenting, bridging culture to close the intergenerational gaps between parents and their children.

VWA also provide carer training, support and respite services to carer of frail aged members.

The forum identified the need to look at:

> educating staff on cultural needs
> providing information, not only in written format, but verbally in their own language
> encouraging community workers to provide consumer feedback directly to hospitals on the patient/families behalf in relation to complaints, advice, suggestions or compliments
> developing a communication strategy explaining the Emergency Department triaging and the reasons why patients who come in via ambulance are being seen before those in the ED waiting area providing information on discharge raising consumer awareness on how to provide feedback and the role of the consumer advisor.

The Vietnamese CALD Community Consumer Experience Forum report was presented to the SA Health Partnering with Consumers and Community Advisory Group. The recommendations have been incorporated into the SA Health CALD Community Experience Strategic Action Plan.

Further community forums will be scheduled in 2015-16 with the new and emerging communities, and migrant youth.
2.1.1.3 Consumer and Community Advisory Committee/Group Guideline and toolkit

In 2014-15, a sub group of SA Health Partnering with Consumers and Community Advisory Group was established to develop a guideline and toolkit to assist health care services to implement the SA Health Framework for Active Partnership for Consumers and the Community and Guide for engaging with Consumers and the Community.

Members of the sub group included Health Consumers Alliance, Southern Adelaide Local Health Network, Mental Health and Substance Abuse, Central Adelaide Local Health Network Consumer and Safety and Quality Unit.

The SA Health Consumer and Community Advisory Committee/Group (CACAC/CAG) policy guideline and toolkit is used by SA Health staff to strengthen and improve the practice of consumer and community engagement processes across SA Health.

The accompanying tools assist staff who are responsible for the facilitation and management of the health care services Consumer and Community Advisory Committee/Group.

The toolkit outlines the recruitment, appointment and governance processes and provides examples of:

- recruitment forms
- appointment letters
- code of conduct
- agreement on confidentiality and conflict of interest
- terms of reference
- meeting agenda
- minute templates
- orientation/introduction guide
- CACAC/CAG member and committee evaluation questionnaires
- education and training requirements for CACAC/CAG members is currently under development.

The SA Health Consumer and Community Advisory Committee/Group Guideline and Toolkit will be released in late 2015.

2.1.1.4 Sitting Fees and Reimbursement for External Individuals

SA Health is committed to engaging with communities and stakeholders, so that better decisions can be made by bringing the voices of the communities and stakeholders into the issues that are relevant to them. Sitting fees recognise the significant contributions made by external individuals that is not generally obtainable from SA Health employees. Reimbursement ensures that external individuals are not out of pocket as a result of their participation.

A new Sitting Fees and Reimbursement for External Individuals Policy Directive was developed following a review over the past 12 months, that has included consumers, carers, community groups and other stakeholders. The Local Health Networks provided an overview of the current consumer and community activities, which were considered as part of the review of the existing policy.

The new policy directive provides greater clarity and consistency of processes that supports SA Health in achieving the strategic objectives of Better Together: Principles of Engagement, the National Safety and Quality Health Services Standard 2 – Partnering with Consumers, and the SA Health A Framework for Active Partnership with Consumers and the Community.

The Sitting Fees and Reimbursement for External Individual policy directive will be released in mid to late 2015.
2. Partnering with consumers

2.1.2 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), a sub-committee of the SA Council on Safety and Quality in Health Care (the Council), and was established in 2007. Membership of CACAC includes consumer and community organisation representatives from:

> Aboriginal Health Council of SA
> Carers SA
> Council on the Ageing SA
> Country Health SA Local Governing Council
> Culturally and Linguistically Diverse (CALD) Community
> Mental Health / lived experience
> Health Consumers Alliance SA (HCA)
> HCA Consumers
> Women's and Children's Health Network

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. CACAC continued to work with the Council 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 includes:

> SA Patient Safety Report for Consumers and the Community and fact sheets (see page 84)
> Culturally and Linguistically Diverse (CALD) consumer resources pilot on interpreter card and posters (see page 65)
> Same Gender Accommodation Policy Directive, Guideline and Toolkit
> Consumer feedback on SA Health consumer information sheets:
  - Essential contacts for advance care directive – consumer information sheet
  - Do you have an advance care directive? - poster
  - Changes to VRE screening and management for Haemodialysis patients.

Following the Premier’s final report on the statewide reform of government boards and committees in Parliament, the CACAC was abolished and the last meeting was held in November 2014. An alternative engagement model was established in 2015.

Picture 15: SA Safety and Quality in Health Care Consumer and Community Advisory Committee members

Top L-R: Deb Sparkes, Jan Wallent, Miriam Cocking, Lyn Whiteway, Professor Villis Marshall (Chair SA Council Safety & Quality)
Bottom L-R: Debra Kay, Trevor Bowler (Chair, CACAC), Annette McGrath, Chris Jones
Absent: Michael Cousins, Amanda Mitchell, Dennis Floyd
2.1.2.1 Same Gender Accommodation

All patients, staying overnight in a South Australian public hospital are to be placed in same gender accommodation, use same gender accommodation facilities, and are not required to move through mixed gender areas to reach their own facilities (except when considered clinically appropriate).

In November 2014, SA Health released the Same Gender Accommodation Policy, Guideline and Toolkit. The policy directive, guideline and toolkit supports all health services to ensure same gender accommodation is available by applying patient centred care principles which includes respecting the patients’ values, preferences and expressed needs prior to their admission.

The Safety and Quality Unit and the SA Safety and Quality in Health Care Consumer and Community Advisory Committee developed the SA Health Same Gender Accommodation policy, guideline and toolkit.

Local Health Networks and clinicians from across SA were invited to review and comment on the draft policy, guideline and toolkit and provide feedback via survey monkey. In total 32 responses were received from the Local Health Networks, and their comments and feedback have been incorporated into the attached policy, guideline and toolkit.

Resources include:

> consumer and staff information on respecting privacy and dignity with patient centred care principles
> flowchart and assessment checklist
> audit tools and fact sheet.

The SA Health Same Gender Accommodation Policy, Guideline, Toolkit and resources are available on the SA Health Hospital Accommodation web page at www.sahealth.sa.gov.au.

Item 7: Consumer and staff information on respecting patients’ privacy and dignity with patient centred care principles
2. Partnering with consumers

2.1.3 Safety and Quality Community Advisory Group

In March 2015, the Safety and Quality Community Advisory Group (SQCAG) was established with representatives from the Aboriginal Health Council SA, Carers SA, Council on the Ageing (COTA), Health Consumers Alliance SA, Mental Health, Multicultural Communities Council SA, Seniors Information Service, Country Health SA Governing Council and Women's and Children's Network.

The Safety and Quality Unit has established a process for all state wide consumer information sheets to be reviewed by the Safety and Quality Community Advisory Group. The SQCAG’s comments and feedback are forwarded to the author for consideration, and feedback is incorporated into the final publication.

An icon has been developed using the Standard 2 Partnering with Consumers symbol to document that the information sheets have been reviewed and endorsed by the SQCAG for consumers and the community.

Item 8: Partnering with Consumers icon documenting information sheet has been reviewed and endorsed by SQCAG

SA Health consumer information sheets which were reviewed and endorsed by SQCAG include:

> Taking care of challenging behaviour

> Falls consumer fact sheets:

1. Strong muscles and bones
2. Eyesight and walking
3. Medicines and balance
4. Dizziness and balance
5. Keeping safe and independent in hospital
6. Comfy feet a long way,
7. Standing up to falls
8. Making your home your haven
9. Strong and steady keep active
10. New mums and bubs can fool too.

> Falls video – Keeping safe and independent in hospital

SQCAG and Local Health Network Consumer Advisory Committee members also provided consumer feedback on the Australian Commission on Safety and Quality in Health Care (ACSQHC) brochure What you need to know about CT scans for children.
Item 9: Taking care of challenging behaviour consumer fact sheet

Taking care of challenging behaviour

Caring for patients, consumers, carers and staff

SA Health recognises that patients, consumers, carers, volunteers and staff all want health services in which health care can be both delivered and received without personal threat or risk.

What is challenging behaviour?

Challenging behaviour is any behaviour with the potential to physically or psychologically harm another person, or self, or property. It can range from verbal abuse through to threats or acts of physical violence.

Where / how does challenging behaviour commonly present?

Challenging behaviour can more commonly occur:
- with patients/consumers who have a particular clinical condition (such as cognitive impairment, mental illness or substance abuse)
- in emergency, traumatic, stressful or emotional situations (such as emergency presentations, intensive care, surgery or childbirth)
- where there is limited access to assistance for workers (such as ambulance services, community mental health or home visits)

How can challenging behaviour cause harm?

Sometimes, it can occur when:
- thoughts, feelings, emotions, physical or mental health status can impact on someone's daily activities
- feeling that there is inadequate treatment or management of symptoms such as nausea, pain or anxiety
- alcohol or drugs have been used.

The diagram below shows the range of challenging behaviour from property damage to physical assault.

Finally, regardless of its limit, challenging behaviour is a barrier to the delivery of care that is safe for consumers and health care workers.

Item 10: Standing up to falls – fact sheet 7

STANDING UP to FALLS

SA Falls and Fall Injury Prevention - Fact Sheet 7

Plan what you would do if you fall over

No one expects to have a fall, but having a plan will help you to be confident and get on with life.

If you spend a lot of time alone, it is worth thinking about how to get help in an emergency, how to get up from the floor and what to do after a fall. Here are some ideas.

Be prepared

- Make daily contact with a relative, friend, neighbour, carer or Telecross service. They will check if you need assistance if they don’t hear from you.
- Ensure your telephone can be reached from the floor, or carry a cordless or mobile telephone with you.
- Consider getting a personal alert system so that you can attract attention quickly in an emergency, such as a fall.
- Leave a spare key with someone you trust, or install a key safe outside your house. This means someone will be able to reach you.
- Discuss your plan with someone you trust.

How would you get up from the floor if you are not badly hurt?

On page three there is a suggested way to get up from the floor. It may be a long time since you tried to get on and off the floor, so it is a good idea to practice this when someone is with you, so that you know what to do.

Check with a physiotherapist or occupational therapist to find the method that best suits you and to help you to practise it safely.
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 (SACCESS) 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 2014, the response rate was 72.4% and 2316 patients were interviewed about their experience in public hospitals, and in 2013, 2427 South Australians were interviewed. Since 2010, a total of 10697 South Australians have been interviewed.

For the first time, a short official community version of the Measuring Consumer Experience Report will be available with an infographic, enabling the information to be provided in a more friendly and easy to read format.

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 and strategies for improvement is required to be developed. Qualitative reports on the satisfied and dissatisfied comments were also provided to the LHNs.


Item 11: Measuring Consumer Experience Report and Community Report
In 2014 SA Health surveyed more than 2,000 consumers to find out more about their public hospital experience. The 51 survey questions provided invaluable information on areas of strength as well those that needed improving to ensure consumers have the best possible hospital experience.

### Performance benchmarks were met in 6 out of 10 care categories

- **Treated with respect and dignity**: More than 92% of consumers felt that they were treated with respect and dignity at all times.
- **Consistency and coordination of care**: 32% got conflicting or inconsistent information from staff.
- **Food**: More than 33% thought they didn’t get enough help at mealtimes.
- **Nurses**: Over 88% of consumers trusted their doctors and nurses, and felt that staff did everything they could to control their pain.
- **Doctors**: Over 90% felt that hospital facilities and staff were clean.
- **Pain**: 20% thought they weren’t getting enough information in hospital.
- **Privacy**: Over 92% were given enough privacy during discussions and examinations.
- **Cleanliness**: 37% of consumers weren’t given written information about what they should or shouldn’t do after leaving hospital.
- **Discharge information**: Over 92% of consumers would recommend their hospital to a friend or relative.

### Domains of care

Measuring consumer experience is divided into ten (10) domains of care 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

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5 Picker Institute Europe website [www.pickereurope.org](http://www.pickereurope.org)
The domains of care, questions and mean scores for 2013 and 2014 are listed in table 16.

Table 16: Summary of mean scores by core domains of care and questions 2013 and 2014

<table>
<thead>
<tr>
<th>Picker core domains of care and actual questions</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistency and coordination of care</td>
<td>77.8</td>
<td>79.1</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>78.8*</td>
<td>80.3*</td>
</tr>
<tr>
<td>Q41 How would you rate how well doctors and nurses worked together?</td>
<td>77.0</td>
<td>77.9</td>
</tr>
<tr>
<td>Treated with respect and dignity</td>
<td>91.8</td>
<td>92.8</td>
</tr>
<tr>
<td>Q40 Overall, did you feel you were treated with respect and dignity?</td>
<td>91.8</td>
<td>92.8</td>
</tr>
<tr>
<td>Involved in decision making</td>
<td>78.4</td>
<td>78.6</td>
</tr>
<tr>
<td>Q14 Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>81.0</td>
<td>79.1</td>
</tr>
<tr>
<td>Q15 How much information about your condition or treatment was given to you?</td>
<td>77.5</td>
<td>78.8</td>
</tr>
<tr>
<td>Q36 Did you feel you were involved in decisions about your discharge from hospital?</td>
<td>77.1</td>
<td>77.7</td>
</tr>
<tr>
<td>Doctors</td>
<td>87.6</td>
<td>88.0</td>
</tr>
<tr>
<td>Q26 When you had important questions to ask a doctor, did you get the answers you could understand?</td>
<td>83.8</td>
<td>84.2</td>
</tr>
<tr>
<td>Q28 Did you have confidence and trust in the doctors treating you?</td>
<td>90.8</td>
<td>91.0</td>
</tr>
<tr>
<td>Nurses</td>
<td>89.2</td>
<td>89.6</td>
</tr>
<tr>
<td>Q30 When you had important questions to ask a nurse, did you get the answers you could understand?</td>
<td>87.8</td>
<td>88.0</td>
</tr>
<tr>
<td>Q31 Did you have confidence and trust in the nurses treating you?</td>
<td>89.5</td>
<td>90.6</td>
</tr>
<tr>
<td>Q32 Did the nurses talk in front of you like you weren’t there?</td>
<td>90.0*</td>
<td>89.9*</td>
</tr>
<tr>
<td>Cleanliness</td>
<td>89.8</td>
<td>89.6</td>
</tr>
<tr>
<td>Q4 In your opinion, how clean was the hospital room or ward you were in?</td>
<td>89.8</td>
<td>90.6</td>
</tr>
<tr>
<td>Q5 How clean were the toilets and bathroom that you used while in hospital?</td>
<td>86.8</td>
<td>87.8</td>
</tr>
<tr>
<td>Q29 As far as you know, did the doctors wash or clean their hands between touching patients?</td>
<td>91.4</td>
<td>91.7</td>
</tr>
<tr>
<td>Q33 As far as you know, did the nurses wash or clean their hands between touching patients?</td>
<td>94.2</td>
<td>93.6</td>
</tr>
<tr>
<td>Pain control</td>
<td>90.2</td>
<td>89.6</td>
</tr>
<tr>
<td>Q7 Do you think staff did everything they could to help control your pain?</td>
<td>90.2</td>
<td>89.6</td>
</tr>
<tr>
<td>Privacy</td>
<td>94.1</td>
<td>92.2</td>
</tr>
<tr>
<td>Q34 Were you given enough privacy when discussing your condition or treatment?</td>
<td>91.7</td>
<td>89.0</td>
</tr>
<tr>
<td>Q35 Were you given enough privacy when being examined?</td>
<td>96.4</td>
<td>95.4</td>
</tr>
</tbody>
</table>
# Picker core domains of care and actual questions

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8</td>
<td>58.0</td>
<td>59.3</td>
</tr>
<tr>
<td>Q9</td>
<td>79.2</td>
<td>77.2</td>
</tr>
<tr>
<td>Q10</td>
<td>49.0</td>
<td>60.3</td>
</tr>
<tr>
<td><strong>Discharge information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q39</td>
<td>60.3</td>
<td>62.8</td>
</tr>
<tr>
<td>Q40</td>
<td>66.4</td>
<td>67.3</td>
</tr>
<tr>
<td>Q41</td>
<td>69.1</td>
<td>71.5</td>
</tr>
<tr>
<td>Q42</td>
<td>80.7</td>
<td>78.9</td>
</tr>
</tbody>
</table>

Source: Measuring Consumer Experience Report 2015

* No is the sought after response for this question

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 (67.6) was recorded for ‘food’ and the highest mean score (92.8) for ‘treated with respect and dignity’.

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

The domains of care where SA public hospitals scored below the SA Health benchmark (mean score of 85) in 2014, 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 in a South Australian metropolitan or country hospital.

**Graph 8: Mean scores for the core domains of care (Picker Institute), SA overall, SACCESS 2013 and 2014**

<table>
<thead>
<tr>
<th>Domains of care</th>
<th>Mean scores 2013</th>
<th>Mean scores 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistent and co-ordinated care</td>
<td>77.8</td>
<td>79.1</td>
</tr>
<tr>
<td>Treated with respect and dignity</td>
<td>91.8</td>
<td>92.8</td>
</tr>
<tr>
<td>Involved in decision making</td>
<td>78.4</td>
<td>78.6</td>
</tr>
<tr>
<td>Doctors</td>
<td>89.2</td>
<td>88.0</td>
</tr>
<tr>
<td>Nursing</td>
<td>89.2</td>
<td>89.6</td>
</tr>
<tr>
<td>Cleanliness</td>
<td>89.8</td>
<td>90.3</td>
</tr>
<tr>
<td>Pain control</td>
<td>90.2</td>
<td>89.6</td>
</tr>
<tr>
<td>Privacy</td>
<td>94.1*</td>
<td>92.2*</td>
</tr>
<tr>
<td>Food</td>
<td>67.5</td>
<td>67.6</td>
</tr>
<tr>
<td>Discharge information</td>
<td>68.8</td>
<td>69.8</td>
</tr>
</tbody>
</table>

Note: Due to changes in ranking/weighting methodology and interviews only being undertaken with patients/consumers from six (6) major country hospitals from January 2014, the 2013 data has been modified so that it can be directly compared with the 2014 data.

* Indicates difference between survey years (P<0.05)

Source: Measuring Consumer Experience Report 2015

Although a number of these domains remain below the target of 85, there has been improvement from the previous year (involvement in decision making 78.6 and consistent and coordinated care 79.1) in 2014.

By looking deeper at responses to individual questions within these domains, we can identify specific areas of improvement. Almost 20% of patients felt that they did not get enough information about their condition or treatment while in hospital. Approximately 37% of patients reported that they were not given any written information about what they should or should not do after leaving hospital, and more than 20% said they were not told who to contact after leaving hospital if they were worried about their condition. Patients reported it was disconcerting when they received conflicting or inconsistent information from staff, and 32% reported that this happened sometimes or often. More than 33% of patients felt they did not get enough help from staff at meal times, although this was a significant improvement compared to 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 2014, the mean score for SA Health consumers of overnight hospital care for the overall Involvement in care and treatment was 73.2 (se: 0.5, 95% CI: 72.2–74.2), which was below the SA Health benchmark.

The mean score of this KPI represents the average of responses to the six question items listed in table 17 ‘involvement in care and treatment’ items, SA overall, SACCESS 2014.

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 17.

Table 17: Involvement in care and treatment items, SA overall, 2014

<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>73.2</td>
</tr>
<tr>
<td>Q20 Were you asked about your dietary needs when you arrived on the ward?</td>
<td>62.8</td>
</tr>
<tr>
<td>Q21 Did anyone ask whether you had any cultural or religious beliefs that might affect the way you were treated in hospital?</td>
<td>35.1</td>
</tr>
<tr>
<td>Q22 If you needed one, did you have access to an interpreter?</td>
<td>64.1</td>
</tr>
<tr>
<td>Q23 Did you feel that you could have refused to have students (medical or nursing) present during your treatment?</td>
<td>84.0</td>
</tr>
<tr>
<td>Q24 When you gave your consent for medical treatment, did you understand the risks, benefits and alternatives of recommended treatment?</td>
<td>90.8</td>
</tr>
<tr>
<td>Q25 Was your right to have an opinion respected?</td>
<td>85.1</td>
</tr>
</tbody>
</table>

Source: Measuring Consumer Experience Report 2015

Of those who could recall, 37.2% reported that they were not asked about their dietary needs either on the ward or at pre-admission. Similarly, 64.9% reported that they were not asked about their cultural or religious beliefs that may affect their treatment. Nearly 35% of the respondents who needed an interpreter reported that they were not offered or could not access an interpreter.

About 16% of respondents felt that they could not comfortably refuse to have a medical student present. Approximately one in ten (9.2%) respondents reported that they did not understand the risks, benefits and alternatives of recommended treatment during the consent process. About 25% of respondents felt that their opinion was respected ‘sometimes’ or ‘never’.

As reported in the Measuring Consumer Experience Report 2015, some 91% of patients said they would recommend the hospital to a relative or friend, and almost 88% rated the overall quality of hospital service as ‘very good’ or ‘good. Although people are often vulnerable or unwell when they come to stay with us, their overall experience in hospital is positive.
2. Partnering with consumers

At the end of the survey, patients were given the opportunity to speak freely about any issues with their hospital stay and almost half (1024 respondents) chose to do so. About a third responded with satisfaction about the care they received during their hospital stay and the remainder responded with dissatisfaction. These comments were analysed across several themes and overall, those commented were most commonly positive about the coordination and integration of care; doctors and nurses; physical comfort; and respect for patients’ values, preferences and expressed needs. Dissatisfaction respondents were most commonly negative about the coordination and integration of care; physical comfort; respect for patients’ values, preference and expressed needs; and doctors and nurses.

The results from SACESS are used to guide policy development, help SA Health reach and exceed its benchmarks and ultimately improve health outcomes for all South Australians. Consumer feedback obtained through the community forums, which are held increase feedback from cultural and linguistically diverse consumers and will also be incorporated into policy development.

SA Health encourages staff to use the Measuring Consumer Experience report to inform their professional development and support their time through highlighting areas where we are performing well and encouraging development in key areas of improvement.

2.2.1.3 Questionnaire review

In October 2014, the Measuring Consumer Experience questionnaire and schematic figure were reviewed by the SACESS Advisory Group with representation from Health Consumers Alliance SA, Health and Community Services Complaints Commissioner, University of Adelaide Population and Outcomes Research Studies and SA Health Safety and Quality Unit.

The questionnaire has been updated to include new questions relating to hospital environment (same gender accommodation and hospital at night), and open disclosure. Questions relating to consumer feedback and patient rights and engagement have been amended. The revised questionnaire will commence with interviews from January 2015.

2.2.2 Measuring Consumer Experience LARS reports

In 2014-15, a suite of Measuring Consumer Experience (MCE) reports have been developed in the LHN Analytics and Reporting System (LARS), from SACESS data.

The MCE LARS reports will ensure that appropriate, timely and valid consumer experience data is available to enable health services to monitor the level of satisfaction with health care services, respond to any changes in satisfaction levels and support hospital planning and evaluations.

The three reports include:

> core domains of care
> qualitative feedback (satisfied/dissatisfied)
> consumer feedback.

The Measuring Consumer Experience reports will be available in late 2015 via LHN Analytics and Reporting Service (LARS).
2.2.2.1 **Safety Learning System (SLS) measuring consumer experience module**

In 2014-15, the Local Health Networks piloted the Safety Learning System Measuring Consumer Experience module for inpatients, outpatients, dental and renal services, to better understand the consumer and community needs in health care.

The SLS Measuring Consumer Experience module increased the number of consumers sharing their experience with health services and SA Health, which are currently excluded from the SA Consumer Experience Surveillance System (SACESS).

The module offers health services organisations multiple options and models to capture consumer experience including hand held devices and hard copy handouts, for data entry into SLS.

**Renal Network**

The Renal Transplant Assessment Clinic patient experience survey and questions were developed by the Renal Clinical Network and the Royal Adelaide Hospital (RAH) Renal Transplant Team. Questions included the ACSQHC national core common patient experience questions.

The survey was mailed out to patients who attended the Renal Transplant Pre-Assessment Clinic at the RAH between 1 January and 30 September 2014. A covering letter and reply paid envelope were mailed out in January 2015, with a response rate of 40%

As reported in the SA Renal Clinical Network *Results of the Patient Survey Trial on Measuring Consumer Experience in the Renal Transplant Assessment Clinic*:

> 95% of patients rated the care they received as very good or good.
> 92% felt that there were always treated with dignity and respect.
> 81% of respondents rated how well the doctors and nurses worked together as ‘excellent’ or ‘very good’.
> 97% received pre-renal transplant education.
> 76% of patients were definitely involved as much as they wanted to be in decisions about care and treatment, with the remaining 24% involved to ‘some extent’.
> 73% felt that the ‘right amount’ of information about their condition or treatment was given to family and friends.
> 86% would recommend the hospital to family or friends.
> 74% patients responded to Question 25: ‘Finally is there anything else you would like to say’?

Responses were summarised into areas of well done (compliments), areas for improvement (statements of dissatisfaction). Themes were identified and improvements are:

> Observations or suggestions of improvement
> Clinic organisation or processes
> Clerical staff
> Medical staff/medical care
> Nursing staff/nursing care

The responses have provided the Renal Service with their patient’s experience and will be used as vignettes to focus on service improvement.
2. Partnering with consumers

SA Dental Service

SA Dental Service (SADS) surveyed a random sample of 250 clients aged over 18 years who had completed an emergency or general course of dental care at a Community Dental Service (CDS) or the Adelaide Dental Hospital (ADH). The survey group included clients living in metropolitan and country areas, as well as being from aboriginal and Torres Strait Islander background and cultural and linguistically diverse (CALD) backgrounds.

As reported in the SA Dental Service SLS Module – Measuring Consumer Experience Report – Pilot phase, of the surveys distributed, 30% were completed and returned with the majority of respondents being satisfied across all relevant patient centred care dimensions. Responses include:

> 97% respondents considered staff to be welcoming and helpful
> 94% respondents felt that they were treated with dignity and respect
> 98% respondents felt that dental staff either ‘definitely’ (86%) or to ‘some extent’ (12%) explained things in a way in which they could understand
> 97% respondents felt they were involved as much as they wanted to be in decisions about their dental care.

In January 2015, the SADS Executive considered the Pilot Phase Report and endorsed the recommendation to implement the Measuring Consumer Experience SLS module on a quarterly basis commencing from February 2015, with the February and August surveys targeting adults and the May and November surveys targeting children.
Case study:

Southern Adelaide Local Health Network consumer surveyors interviewing consumers

The Southern Adelaide Local Health Network (SALHN) pilot commenced on 1 July until 1 October 2014 in the Flinders Medical Centre Outpatients Department - Surgical, Cancer and Allied Health Clinics.

The face-to-face method was used to collect feedback with hard copy questionnaires being filled in by consumer surveyors interviewing consumers in waiting areas.

Following endorsement from the Chief Operating Officer, Operation Manager – Outpatients and Manager Strategic Projects, SALHN rolled out the Consumer to Consumer Outpatient Surveyor Program to Repatriation General Hospital and Noarlunga Hospital in April 2015.

From 1 July 2014 to 30 June 2015, a total of 420 consumers have been interviewed in SALHN Outpatient Clinic areas.

SALHN has developed quality improvement plans for areas based on the suggestions and feedback by Consumers, designed infographic reports, introduced consumer experience reporting to SALHN Outpatient Leadership Group and is commencing the monitoring of reports by the SALHN Partnering with Consumers Advisory Group and Clinical Council.

Feedback from the consumer surveys have resulted in a concierge service, implementation of waiting time boards, review of patient information and updating of new Consumer Feedback brochures to name a few.

Picture 16: Jo and Tommy – consumer surveyors in SALHN outpatients
2. Partnering with consumers

2.3 Consumer partnership in service measurement and evaluation

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

The third South Australian Patient Safety Report for Consumers and Community was released in February 2015. 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:

> Accreditation.
> Partnering with Consumers – Measuring consumer experience.
> Cultural and Linguistically Diverse (CALD) Consumer Experience Forums.

Individual fact sheets have also been developed on:

> Partnering with consumers and measuring consumer experience – fact sheet 1.
> Preventing and controlling healthcare associated infections – fact sheet 2.
> Preventing and managing pressure injuries – fact sheet 3.

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

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

The Partnering with Consumers and the Community Executive Summary and fact sheets are available on the Safety and Quality section of the SA Health website www.sahealth.sa.gov.au/safetyandquality.

Further information is available on the Safety and Quality section of the SA Health website Partnering with Consumers and the Community page at www.sahealth.sa.gov.au/safetyandquality.
3 Preventing and controlling healthcare associated infections
3. Preventing and controlling healthcare associated infections

Infection prevention and control aims to reduce the incidence of healthcare associated infections and the development of resistant pathogens. This is accomplished by the isolation of patients with transmissible infections 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

SA Health has a robust governance structure in place aimed at the minimisation of healthcare associated infection and the prevention of cross-transmission of infectious diseases. At the statewide level this is monitored by the Healthcare Associated Infection Advisory Group, with representation from each of the Local Health Networks, SA Ambulance Service and SA Pathology. Local Health Networks each have internal governance arrangements in place to review the effectiveness of their local Infection Prevention and Antimicrobial Stewardship programs.

The SA Health 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 and antibiotic usage in hospitals
- promotion and implementation of best practice guidelines for infection prevention
- promotion of best practice antimicrobial prescribing (antimicrobial stewardship).

The Service also coordinates the SA Health Expert Advisory Group on Antimicrobial Resistance (SAAGAR) and two consultative networks of infection control professionals with representatives from a variety of clinical settings across both public and private sectors.

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7 National Safety and Quality Health Service Standards (September 2011), Australian Commission on Safety and Quality in Health Care
3.1.1 Prevention of healthcare associated infections accreditation resource

Item 14: Standard 3 Preventing and controlling healthcare associated infections accreditation resource guide

The SA Health Preventing and controlling healthcare associated infections accreditation resource guide that was developed to support health services was revised and updated in 2015. The resource provides links to South Australian tools and documents that can be used to demonstrate an action in the 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.

3.1.2 SA Health healthcare associated infection web area

The SA Health healthcare associated infection section of the SA Health website at www.sahealth.sa.gov.au/infectionprevention provides a number of resources and information on infection prevention and control and includes:

- Governance and Standards
- Antimicrobial stewardship
- Prevention and management of infections in healthcare settings
- Clostridium difficile infections
- Multidrug-resistant organisms
- Healthcare associated infection surveillance.

The web area also contains links to the SA Health online eLearning courses ‘Aseptic Technique’ and ‘Safe Use of Personal Protective Equipment’.

3.1.3 Surveillance of healthcare associated infection

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 multidrug-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 9. The graph shows the total Staphylococcus aureus bloodstream infections and the Staphylococcus aureus bloodstream infections which are methicillin-resistant (MRSA).
3. Preventing and controlling healthcare associated infections

Graph 9: Hospital-acquired *Staphylococcus aureus* bloodstream infection 2009-15

Methicillin-resistant *Staphylococcus aureus* (MRSA) is an important indicator organism for the control of multidrug-resistant organism transmission within the healthcare setting. Graph 10 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 relatively stable.

Graph 10: Hospital-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) rates 2009-15

Source: SA Health Healthcare Associated Infection Surveillance Program, Communicable Disease Control Branch
Multidrug-resistant gram-negative organisms (MRGN), particularly the extended spectrum beta lactamase (ESBL)-producing \textit{E. coli} and \textit{Enterobacter} species, have increased significantly over the last few years, although this has stabilised over 2014-15, as shown in graph 11. The increasing trend has been noted worldwide and may represent the increased community-associated acquisition of these organisms from exposure during travel to countries with high endemic rates of colonisation with 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.

**Graph 11: Hospital-acquired multi-resistant Gram-negative bacteria (MRGN) rates 2009-15**

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

3.2 Infection prevention and control strategies

3.2.1 Promotion and implementation of best practice guidelines for infection prevention

The Infection Control Service has developed and revised a number of policy directives, guidelines and fact sheets which include:

**Policy directives:**
- Aseptic Technique
- Cleaning Standard for Healthcare Facilities
- Hand hygiene
- Healthcare Associated Infection Surveillance
- Management of the Healthcare Environment to Minimise the Risk of Transmission of Infection

**Guidelines:**
- Hand hygiene
- Infection Prevention and Control during Construction and Renovation at Existing Healthcare Facilities
- Management of Patients with Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Management of Patients with Vancomycin-resistant Enterococci (VRE)

**Fact sheets and resources**
- *Clostridium difficile*
- Consumer information on Vancomycin-resistant Enterococci (VRE) and Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Infection Prevention and Control during Construction and Renovation: Toolkit
- Management of Infectious Diseases summary table
- Safe use of Anaesthetic Equipment and Prevention of Cross-infection
- Safe use of ortho-phthalaldehyde (OPA)
- Standard 3 – preventing and controlling healthcare associated infection – Audit Tools


3.2.2 Improving hand hygiene compliance

SA Health continues to support the national hand hygiene program by monitoring compliance and submitting data to Hand Hygiene Australia. South Australian hospitals with greater than 25 acute beds are required to submit data three times a year.

The state's performance has continued to improve over time. The South Australian target for compliance is 75% (the national target is 70%). From 1 July 2015 the state target will be increased to 85%. The overall compliance for the state is currently greater than 80%.

Compliance rates stratified by moments one to five are presented in graph 12. Moments one and two, i.e. before patient contact, continue to have lower compliance than after patient contact, i.e. moments three, four and five. However, with the implementation of the Aseptic Technique online eLearning course moment two (before a patient procedure) continues to improve.
Compliance rates demonstrated by specific healthcare worker groups can be seen in graph 13. Most healthcare worker groups have improved their hand hygiene compliance; however doctor’s compliance remains below the state target at 72%.

Graph 12: South Australian compliance rates by moment 2012-15

Graph 13: South Australian compliance rates by healthcare worker group 2012-15*

* AH = allied health; BL = phlebotomist; DR = doctor; N = nurse; SAH = student allied health; SDR = student doctor; SN = student nurse
3.2.3 Education and training

In 2014-15, 36 healthcare workers attended a one day basic infection control training workshop for infection control link nurses or champions in South Australian healthcare facilities.

60 staff attended introductory and intermediate surveillance workshops during the past year. These workshops provided basic surveillance training for novice infection control staff and consolidated knowledge in the intermediate workshop for infection control staff with a surveillance role.

Two online eLearning courses are now available to assist and support staff in aseptic technique and the safe use of personal protective equipment.

The online eLearning courses are available on the SA Health intranet site.

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.

In 2014-15 nearly 2,000 posters and pamphlets were distributed to various organisations which included child care centres, schools, residential care facilities and other general businesses.

3.3 Cleaning, disinfection and sterilization

SA Health has developed a Cleaning Standard, the intent of which is to ensure that all hospitals have a consistent, high quality cleaning system in place that fulfils the mandatory criteria for assessment against the National Safety and Quality Health Service (NSQHS) Standard 3.15 which requires healthcare facilities and the associated environments are clean and hygienic. Reprocessing of equipment and instrumentation meets current best practice guidelines, *Australian Guidelines for the Prevention and Control of Infection in Healthcare, 2010*.

The SA Health Cleaning Standard was endorsed by SA Health Executive in December 2014 and includes tools to assist with risk assessment, cleaning schedules and an auditing system. The Cleaning Standard is currently being implemented across South Australian healthcare facilities.

The Cleaning Standard is available via the SA Health policies page, and an e-document is available on the SA Health website [Environmental hygiene in health care](#) page.

**Item 15: SA Health Cleaning Standard**
3. Preventing and controlling healthcare associated infections

3.4 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).

National Safety and Quality Health Service Standard 3 includes actions required of all hospitals in the implementation of AMS. Hospitals are required to provide their clinical workforce access to current endorsed guidelines on antimicrobial usage, monitor their rates of antimicrobial use and continually improve the effectiveness of their AMS programs.

The Infection Control Service assists hospitals to meet these standards in a number of ways:

- A group of South Australian experts on antimicrobial usage (SAAGAR) provides guidelines for prescribing of these medicines for prevention and treatment of infections. These guidelines are regularly reviewed to ensure they reflect current best practice. The latest guidelines are available on the Antimicrobial Guidelines page of the SA Health internet.

- The 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, measures antibiotic usage rates in over 140 hospitals including 19 South Australian hospitals. South Australian usage patterns have been compared with other Australian states. The SA rate is similar to the overall national rate (955 DDD/1000OBD and 936 DDD/1000OBD respectively) and is lower than New South Wales and Tasmania.

- To assess improved effectiveness of AMS programs, the Infection Control Service developed an AMS self evaluation toolkit which is available for hospitals to download from the SA Health website. The tool helps hospitals identify areas where AMS strategies can expand, and provides evidence of ongoing improvement of AMS in their facility.

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. Usage data are used to analyse changes in the relative usage of broad versus narrow spectrum agents over time.

Since 2011, the data shown in graph 14 illustrates the small but encouraging change to a lower percentage of broad spectrum agents used in South Australian public hospitals.
Graph 14: Broad spectrum antibiotic* use as a proportion of total antibiotic use in 13 SA public hospitals 2004-14

In particular, classes of antibiotics such as the fluoroquinolones and third generation cephalosporins have been linked with emergence of multi-resistant bacteria. Graph 15 shows these classes plotted as a percent of total use over an 11 year period. Usage of fluoroquinolone antibiotics as a percent of total usage has declined since 2008. To a lesser degree, so too have third generation cephalosporins.

Graph 15: Fluoroquinolone and third generation cephalosporin usage as a proportion of annual total antibiotic usage in 13 SA public hospitals 2004-14

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

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/.
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.

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 sub groups. 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. The membership was updated in 2014 to reflect changes in LHN committee structures, to enhance communication and input across services and to ensure greater engagement with the ambulance sector and consumers.

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.

4.1.1 Medication safety accreditation

A key part of the medication safety work plan is supporting health services in achieving accreditation to the NSQHS Standards. During 2014–15, many of the Local Health Networks underwent organisational accreditation utilising the National Safety and Quality Health Service (NSQHS) Standards. Medication safety is a mandatory component of the standards. Some of the key focus areas included:

- high risk medicines
- safe storage/security of medicines
- reported medication incident review with quality improvements
- medication safety systems assessments with action plans for improvement
- adverse drug reactions
- ensuring continuity of medication management
- communicating medicine information with consumers.

SA Health staff should be congratulated for their high commitment to significantly improve medication safety within their networks both in preparation for accreditation and on an ongoing basis.
4.1.2 **SA Health medication safety web area**

The [SA Health Medication Safety](https://www.sahealth.sa.gov.au/medicationsafety) section on the SA Health website 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
- education and training
- medication alerts and notices
- high risk medicines
- links to resources.

One of the features on the web area is the Medication Safety education and training web page.

This contains information on how to access SA Health Medication Safety online eLearning courses including:

- ‘Labelling for Safety’, a course about the National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines.
- Introduction to High Risk Medicines.
- High Risk Medicines: Insulin.

and links to other online training courses on:

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

4.1.3 Medication incidents

Medication incidents are reported through the Safety Learning System (SLS) Incident Management module 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 2014-15, equating to 22.5% (n=12054) of the total incidents reported in South Australia for the period 1 July 2014 to 30 June 2015.

Tables 18 and 19 highlight the type of medication incident and the 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 18: Number of medication incidents reported by year by level 2 classification and SAC 2014-15

<table>
<thead>
<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>
</tr>
</thead>
<tbody>
<tr>
<td>Administration of a medicine</td>
<td>1</td>
<td>7</td>
<td>1791</td>
<td>4079</td>
<td>5878</td>
</tr>
<tr>
<td>Advice and information transfer</td>
<td>0</td>
<td>0</td>
<td>40</td>
<td>105</td>
<td>145</td>
</tr>
<tr>
<td>Monitoring or follow up of medicine use</td>
<td>1</td>
<td>1</td>
<td>74</td>
<td>168</td>
<td>244</td>
</tr>
<tr>
<td>Other medication error</td>
<td>0</td>
<td>1</td>
<td>137</td>
<td>584</td>
<td>722</td>
</tr>
<tr>
<td>Patient’s reaction to medication</td>
<td>0</td>
<td>1</td>
<td>62</td>
<td>61</td>
<td>124</td>
</tr>
<tr>
<td>Prescribing and ordering process</td>
<td>0</td>
<td>2</td>
<td>1466</td>
<td>1247</td>
<td>2715</td>
</tr>
<tr>
<td>Storage and accountability of medicines</td>
<td>0</td>
<td>0</td>
<td>114</td>
<td>473</td>
<td>587</td>
</tr>
<tr>
<td>Supply/dispensing of medicines</td>
<td>0</td>
<td>0</td>
<td>230</td>
<td>931</td>
<td>1161</td>
</tr>
<tr>
<td>Actual SAC not confirmed</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>478</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>12</td>
<td>3914</td>
<td>7648</td>
<td>12054</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

Table 19: Top ten medication related incidents by level 3 classification and SAC 2014-15

<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>0</td>
<td>4</td>
<td>538</td>
<td>1812</td>
<td>2354</td>
</tr>
<tr>
<td>Medication omitted</td>
<td>0</td>
<td>2</td>
<td>750</td>
<td>1550</td>
<td>2302</td>
</tr>
<tr>
<td>Medication not prescribed or charted</td>
<td>0</td>
<td>0</td>
<td>1057</td>
<td>191</td>
<td>1248</td>
</tr>
<tr>
<td>Wrong dose</td>
<td>0</td>
<td>0</td>
<td>250</td>
<td>555</td>
<td>805</td>
</tr>
<tr>
<td>Wrong frequency</td>
<td>0</td>
<td>0</td>
<td>193</td>
<td>411</td>
<td>604</td>
</tr>
<tr>
<td>Wrong medicine</td>
<td>0</td>
<td>2</td>
<td>127</td>
<td>340</td>
<td>469</td>
</tr>
<tr>
<td>Invalid order</td>
<td>0</td>
<td>0</td>
<td>117</td>
<td>315</td>
<td>432</td>
</tr>
<tr>
<td>Delayed or not dispensed</td>
<td>0</td>
<td>0</td>
<td>94</td>
<td>301</td>
<td>395</td>
</tr>
<tr>
<td>Duplicate medication</td>
<td>0</td>
<td>0</td>
<td>93</td>
<td>240</td>
<td>333</td>
</tr>
<tr>
<td>Incorrect storage</td>
<td>0</td>
<td>0</td>
<td>53</td>
<td>179</td>
<td>232</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 16.

Graph 16: Top ten drugs reported in medication incidents 2014-15

Source: Safety Learning System
4. Medication safety

4.2 Documentation of patient information

4.2.1 National Inpatient Medication Chart (NIMC)

SA Health supports 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 health 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.

> South Australia is implementing, in a staged process, an Enterprise Patient Administration System (EPAS) which incorporates electronic prescribing. A paper version of the NIMC, the EPAS Downtime form is available if the system goes down for a period of time. The SA NIMC Adult Acute Care NIMC and the EPAS Downtime form have been updated according to the NIMC Jurisdictional Local Management Guidelines. The updated version of the NIMC includes: Once only, pre-medication, telephone orders and nurse initiated medicines section. This section now includes two column spaces for two nurses/midwives to document telephone orders, in alignment with the national version of the NIMC.

> ‘Adverse Drug Reaction’ section

> A statement ‘COMPLETE ALERT SHEET IN MEDICAL RECORD’ has been added to encourage timely completion of the Alert Sheet in compliance with the Preventing Adverse Drug Events Policy.

> ‘NOT A VALID ORDER UNLESS LEGIBLE’ has been added to the side of the chart to encourage clarity of orders and to support staff to question unclear orders.

Item 16: Updated National Inpatient Medication Chart (NIMC) fact sheet

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 supporting resources

Information and resources for the safe management of high risk medicines provided by SA Health can be accessed via the High Risk Medicines web area and include the High Risk Medicines Management Policy Directive and Guideline. The policy and guideline aim to facilitate improved patient safety and minimisation of patient harm through the safe storage, prescribing, dispensing and administration of high risk medicines.

4.3.2 High risk medicines online eLearning courses

4.3.2.1 Introduction to High risk medicines

The Introduction to High Risk Medicines online eLearning course was released in the second half of 2014. The course compliments the High Risk Medicines Management policy and guideline with the following learning objectives:

> 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.

There has been significant and consistent uptake from SA Health staff since the course was released.
4. Medication safety

4.3.2.2 High risk medicines: Insulin online eLearning course

The High Risk Medicines: Insulin online eLearning course was released in March 2015. The aim of the online eLearning course is to:

> equip staff with knowledge of common errors with insulin and strategies to assist in their prevention, and
> improve patient safety by promoting safe prescribing, dispensing and administration of insulin.
Picture 18: Learning outcomes of the ‘High Risk Medicines: Insulin’ online eLearning course

Learning Outcomes
On completion of this module you will be able to:
• describe why insulin is a high risk medicine
• recognise differences between different insulin products
• discuss common types of errors with insulin and common contributing factors
• identify key strategies to promote safe use of insulin
• describe resources/tools available to help in the safe management of insulin

Picture 19: Screenshot from ‘High Risk Medicines: Insulin’ online eLearning course

A high risk medicine
Insulin is universally recognised as a high risk medicine. Incidents resulting in serious patient harm and death can occur when it is not managed safely.

Insulin is a high risk medicine as it has a narrow therapeutic range – there is little difference between a sub-therapeutic dose, therapeutic dose and a toxic dose.
• Underdosing or failing to administer required doses of insulin can cause hypoglycaemia (low glucose levels) and may lead to life-threatening ketonacidoses.
• An insulin overdose may cause hyperglycaemia (high blood glucose levels) and lead to seizures, coma and death.

While insulin-related incidents can result in serious or fatal patient outcomes, they can also have a substantial impact in other ways.
4. Medication safety

Picture 20: Screenshot from ‘High Risk Medicines: Insulin’ online eLearning course

Use of insulin in Australia

Insulin is widely used in Australia. There are just over 1 million people with diabetes in Australia, with around 31% (just over 350,000) of these people requiring insulin therapy. 4

With the large number of people using insulin in Australia, it is likely that there are many patients requiring insulin therapy in our hospitals and health services at any time.

Picture 21: Activity from ‘High Risk Medicines: Insulin’ online eLearning course

Activity

Look at these real examples of insulin orders and answer the questions.

Example 1

What insulin do you think is required? 

Enter the dose (in number of units) you think is required here: 

Do you think this insulin dose should be administered to the patient? 

If yes, how sure are you?

Not at all 25% 50% 75% 100%

Example 2

What insulin do you think is required? 

Enter the dose (in number of units) you think is required here: 

Do you think this insulin dose should be administered to the patient? 

Yes No
4.3.3 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 August 2014, a Medication Safety Notice was issued to remind staff of the importance of good aseptic technique and proper storage of injectable medicines. This alert was a follow up to an alert about cases of bacteraemia which may have been attributed to injectable medicines. The alert highlighted that the outer surface of rubber stoppers and inner surface of injection vials and caps are not sterile and the importance of following good aseptic technique when preparing and administering injectable medicines.

Item 17: Medication Safety Notice – Aseptic Technique

In response to a report involving the administration of medicines or substances to patients who have a known previous reaction or allergy, a safety notice entitled ‘Preventing anaphylaxis – cases of known drug allergy’ was released in March 2015. The safety notice highlights the need to refer to documentation of allergies at all points of care. These incidents can be associated with severe harm and are highly preventable.

Item 18: Medication Safety Notice – Preventing anaphylaxis – cases of known drug allergy

4.3.4 New oral anticoagulants

Apixaban, rivaroxaban and dabigatran are ‘new’ oral anticoagulants, often referred to as NOAC. They are listed on the Pharmaceutical Benefits Scheme (PBS) and available via the South Australian Medicines Formulary for the treatment and prevention of thrombo-embolic disease, subject to certain criteria.

NOAC are different to existing oral anticoagulants, in particular warfarin, in their monitoring requirements, drug interactions and the limited options for reversal. Bleeding complications with NOAC are potentially severe and need to be managed carefully. NOACs, like other anticoagulants, are considered high risk medicines.

4.3.4.1 Clinical guideline for the safe prescribing of new oral anticoagulants; apixaban, rivaroxaban and dabigatran

The clinical guideline for the safe prescribing of new oral anticoagulants; apixaban, rivaroxaban and dabigatran guideline was developed for SA Health staff to safely use NOAC by assisting them to:

- recognise the medicines by generic and trade name
- manage the risk of thrombosis versus the bleeding risk
- consider individual patient bleeding risk factors
- understand the significance of different coagulation test results and drug interactions
- make appropriate decisions regarding surgery and neuraxial procedures.

4.3.4.2 Clinical guideline for the management of bleeding related to apixaban, rivaroxaban and dabigatran

A clinical guideline for the management of bleeding associated with NOAC outlines the action that should be taken by SA Health staff when a patient presents with bleeding.

The clinical guidelines are available on the Medicines and drugs section of the SA Health website Medicines and prescribing: Policies and guidelines page.
4.4 Continuity of medication management

4.4.1 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).

During 2014-15, QUMSA has focussed on the following areas of its workplan:

> engaging and empowering consumers
> pain medication management
  - information for paediatric patients, and their carers, given opioids for the short term treatment of acute pain
> QUM guiding principles and position statements
  - development of guiding principles to achieve continuity in medication management on transition of care from hospital to other health care facilities – Interim Medication Administration Chart.

4.4.1.1 Prescribing guidelines for the pharmacological management of symptoms for adults in the last days of life

Many people who die in Australia receive their end-of-life care in acute hospitals. Whilst some of these patients are referred to palliative care specialists at this time, many are managed by their medical or home teams. To assist clinicians, who are not palliative care specialists, are able to provide timely and appropriate management of symptoms at the end-of-life, readily accessible guidelines have been developed. The guidelines are complementary to the models of practice for resuscitation and care planning decision, contained within the Resuscitation Plan 7 Step Pathway recently introduced by SA Health.

4.5 Communicating with patients and carers

Effective communication and shared decision-making, between consumers and healthcare professionals has been linked to increased patient satisfaction, information recall and compliance with treatment regimens. With the assistance of consumers and multi-disciplinary health professionals, SA Health has produced a My Medicine My Choice brochure for consumers to support them when they make decisions about their health.

Consumers are prompted to be aware of who is in their health care team and who can help them make decisions. The brochure encourages consumers to:

> ask questions
> be clear about their treatment choices, including wait and watch
> know what is important to them
> ask about evidence, risks and benefits.

The take home messages include:

> be an active member of your health care team
> know your treatment choices
> what to consider if choosing a medicine.

**4. Medication safety**

**Item 21: My Medicine My Choice brochure**

**Making the Decision**

When deciding between treatments, your choice depends on what matters the most to you.

- [ ] Do you understand the choices?
- [ ] Have you had enough time to make a decision?
- [ ] Do you feel comfortable to say "no"?
- [ ] Are you aware you can change your mind?
- [ ] Do you have any other concerns?

**Things for you to think about if you choose a medicine.**

- Knowledge: Which options are available and what are the benefits and risks of each option?
- Values: Which benefits and risks matter the most to you?
- Choice: Do you feel comfortable you have made the best choice for you?
- Communication: Who will you share your decision with?

**For more information**

Medicines and Technology Policy and Programs
SA Health
11 Hindmarsh Square
Adelaide SA 5000
Tel: (08) 8224 2499
www.sahealth.sa.gov.au/a1a

Public A1-IA

**Learn about medicines. Know your choices.**

Start a conversation with your health care team.

---

**Knowledge**

- What is most important to you – possible improvement in your health or concern about side effects? Medicines can make you feel better and help you get well, however they have risks as well as benefits and not all medicines work the same way in all people.
- The benefits of medicines are the helpful effects you get when you use them such as curing an infection, lowering blood pressure or preventing stroke. The risks are the chances that you may experience something unwanted or unexpected. Risks can be common side effects such as a slight headache or more serious side effects such as bacteria becoming resistant to antibiotics or liver damage.
- The best choice depends on your particular situation. It is not always clear if a benefit will be achieved. People should talk to their health care team for advice. You may choose to start a medicine and check its effects before deciding to continue or find another option.

**Values**

- Things to consider when thinking about benefits and risks include:
  - Medicine name: ___________________________
  - Benefits: ___________________________
  - Side effects: ___________________________

**Choice**

- What are the benefits for you?
  - ___________________________
  - ___________________________

- What are the side effects you may experience?
  - ___________________________
  - ___________________________

- What do you need to watch out for?
  - ___________________________
  - __________________________

**Communication**

- Who will you share your decision with?
  - ___________________________
  - __________________________

---

**SA Health**

**My Medicine My Choice**

A guide to help you make decisions about your health in partnership with your health care team.

---

**Patient decision aids can help you decide what is important to you.** Ask your health care team to check the Ottawa Health Research Institute website: http://decisionaid.ca/uk

Think about what your choices are and ask about the chance they will work for you.

It’s usually ok to ask for more time to decide or make another appointment if you are not sure about your options. Know that you can seek a second opinion if you are unsure.

When choosing a medicine:

- How do you find the evidence? Sources of balanced, evidence-based and accurate information can be obtained from:
  - Your health care team.
  - Consumer medicine information leaflets available from your pharmacist.
  - NPS MedicineWise: www.medicinewise.org
  - Health Direct Australia: www.healthdirect.gov.au
  - Health Direct 1800 022 222
  - Information from online forums, current affairs television programs, magazines and newspapers is less balanced and should be considered with caution.

**Weigh the risks and benefits of your options**

- What are the benefits for you?
  - ___________________________
  - __________________________

- What are the side effects you may experience?
  - ___________________________
  - __________________________

- What do you need to watch out for?
  - ___________________________
  - __________________________

---

**Medication Safety**

Item 21: My Medicine My Choice brochure

**Patient Safety Report 2014-2015**
5 Patient identification and procedure matching
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 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 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.

<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>Patient incorrectly identified</td>
<td>0</td>
<td>1</td>
<td>57</td>
<td>205</td>
<td>10</td>
<td>273</td>
</tr>
<tr>
<td>Diagnostic images/specimens - mislabelled/unlabelled</td>
<td>0</td>
<td>0</td>
<td>109</td>
<td>148</td>
<td>15</td>
<td>272</td>
</tr>
<tr>
<td>Wrong patient</td>
<td>0</td>
<td>0</td>
<td>54</td>
<td>153</td>
<td>4</td>
<td>211</td>
</tr>
<tr>
<td>Healthcare record/card - mislabelled</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>49</td>
<td>3</td>
<td>59</td>
</tr>
<tr>
<td>Test results/reports - mislabelled</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>21</td>
<td>1</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>1</td>
<td>233</td>
<td>576</td>
<td>33</td>
<td>843</td>
</tr>
</tbody>
</table>

%  
0.0%  
0.1%  
27.6%  
68.3%  
3.9%  
100.0%

Source: Safety Learning System


---

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

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.

6.1 Governance and leadership for effective clinical handover

The SA Health Clinical Handover Policy Directive defines accountability for ensuring organisational structures are in place for ensuring clinical handover procedures and processes are in place.

6.1.1 Clinical handover online eLearning course

The Clinical handover online eLearning course promotes best practice clinical handover and will provide a basis for the health care team to adapt clinical handover processes to meet specific needs and clinical context.

The course is intended for clinicians involved in direct and indirect patient care but is also valuable for health care team members who support clinicians in clinical handover, for example ward clerks. This course continues to be in demand with 4887 people completing the course this year.

Picture 22: Clinical handover online eLearning course screen shot

---

9 National Safety and Quality Health Service Standards (September 2011), Australian Commission on Safety and Quality in Health Care
6.1.2 Communication and teamwork related incidents

Communication and teamwork are one of the most common contributing factors to incidents. As a primary type of incident, the 2014-15 Safety Learning System identifies communication and teamwork related incidents as the ninth most frequently reported incident. The top 10 communication and teamwork related incidents are outlined in table 21 below.

Inadequate communication remains the most frequently reported type of communication and teamwork incidents.

Table 21: Top ten communication and teamwork related incidents and result 2014-15

<table>
<thead>
<tr>
<th>Level 2 classification</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>Communication inadequate</td>
<td>1</td>
<td>2</td>
<td>185</td>
<td>405</td>
<td>40</td>
<td>633</td>
</tr>
<tr>
<td>Communication - other</td>
<td>0</td>
<td>3</td>
<td>71</td>
<td>213</td>
<td>19</td>
<td>306</td>
</tr>
<tr>
<td>Incomplete/absent handover</td>
<td>0</td>
<td>1</td>
<td>107</td>
<td>176</td>
<td>14</td>
<td>298</td>
</tr>
<tr>
<td>Information not available/incomplete/verified</td>
<td>0</td>
<td>1</td>
<td>53</td>
<td>103</td>
<td>11</td>
<td>168</td>
</tr>
<tr>
<td>Accountability for action or follow up not clear</td>
<td>0</td>
<td>1</td>
<td>34</td>
<td>48</td>
<td>8</td>
<td>91</td>
</tr>
<tr>
<td>Communication failure with patient, parent or carer</td>
<td>0</td>
<td>0</td>
<td>17</td>
<td>64</td>
<td>6</td>
<td>87</td>
</tr>
<tr>
<td>Instructions not clear</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>45</td>
<td>5</td>
<td>64</td>
</tr>
<tr>
<td>Information/concern/risk not escalated</td>
<td>0</td>
<td>1</td>
<td>30</td>
<td>25</td>
<td>1</td>
<td>57</td>
</tr>
<tr>
<td>Roles and responsibilities of staff not clear</td>
<td>1</td>
<td>1</td>
<td>11</td>
<td>33</td>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td>Patient risk/deterioration not communicated</td>
<td>0</td>
<td>0</td>
<td>23</td>
<td>18</td>
<td>4</td>
<td>45</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2</td>
<td>10</td>
<td>545</td>
<td>1130</td>
<td>112</td>
<td>1799</td>
</tr>
<tr>
<td><strong>%</strong></td>
<td>0.1%</td>
<td>0.6%</td>
<td>30.3%</td>
<td>62.8%</td>
<td>6.2%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System
6. Clinical Handover

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:

Royal Adelaide Hospital Emergency Department Education

The Royal Adelaide Hospital Emergency Department (ED) clinicians know first hand the critical importance of effective teamwork and communication in proving safe, quality care. Their commitment to further improve their teamwork and communication skills is demonstrated by their introduction of the TeamSTEPPS® program in November 2014.

The program involves training the team in the key skills and strategies for effective teamwork and communication. The Emergency Department has a workforce of approximately 370, with most working rotating shifts over a 24 hour/7 day a week roster. Education model has been adapted to allow for a more flexible approach to learning. The Emergency Department team is the first to use the new on-line learning program. Sixty team members were trained to be TeamSTEPPS® Trainers by completing an on-line learning program followed by a one day workshop. The remainder of the ED team then undertook the on-line learning and attended a three hour face-to-face training session.

Picture 23: Registered Nurse completing the TeamSTEPPS® online eLearning course

A team approach to improving patient safety in the Emergency Department

The Emergency Department Team agreed their first patient safety improvement initiative would be the reduction of “Code Black” calls (emergency response team call for assistance when a person perceives their safety may be at risk). Some people attending the Emergency Department are in a state of crisis and many factors can influence their behaviour. Behaviour may escalate and become challenging (perceived as potentially unsafe). Early intervention can often avoid the situation from becoming worse. A team “huddle”,
a quick team meeting to revise the clinical plan, is one strategy that is effective in preventing behavior from escalating and reducing the need for a Code Black team to respond to the situation (for further information see “Code Black” on page 163 of this report). Security staff in the Emergency Department are included in the response and in some cases may be the first to observe signals that may indicate a person’s behaviour is escalating.

The actions taken following a team “huddle” are designed to meet the immediate need of the person who is distressed and provides a respectful and empathic approach to address the person’s concerns.

**Picture 24: Staff huddle**

![Image of staff huddle]

While the intervention is in early days, the inter-disciplinary team “huddles”, inclusive of security staff, has already been effective in the prevention of “Code Black” calls.

**Embedding the new teamwork and communication skills**

Coaching is being used to embed teamwork and communication skills reliably into everyday practice. Clinicians in the Emergency Department were trained to coach their peers in agreed communication and teamwork behaviours.

**Picture 25: Royal Adelaide Hospital Coaches**

![Image of Royal Adelaide Hospital Coaches]

M Wake, H Rohrlach, S Owens, C King, L Moorcraft, L Rivett, B White, N Butler, W Brownlee, E Collins (TeamSTEPPS Project Coordinator), O Van Meerv
6.2.1 Clinical Handover Processes Research and Evaluation

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 2015.

Based on the data from the study, a mental health clinical handover audit tool, mCHAT was developed, trialled and now available for use. The tool assesses four components of handover:

1. Handover environment or context
2. Handover process
3. Informational process and outcomes
4. Interactional practices

It is designed to assist mental health services in meeting the requirements of the Standard 6, Clinical Handover, of the National Safety and Quality Health Service Standards and is based upon research evidence from mental health handovers.

Item 22: An excerpt of the informational process: ISBAR section of the mental health clinical handover audit tool (mCHAT).

<table>
<thead>
<tr>
<th>Informational process: ISBAR</th>
<th>Yes or No?</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Each patient has been identified with a minimum of three identifiers</td>
<td></td>
</tr>
<tr>
<td>S For each patient the giver provides the reason for presentation, patient’s current state and, if relevant, patient’s current legal status</td>
<td></td>
</tr>
<tr>
<td>B Giver provides clear statement of patient’s clinical background including any co-morbidities and substance abuse, clinicians and carers involvement, care plan, medication, and relevant social factors.</td>
<td></td>
</tr>
<tr>
<td>A Giver provides clear statement of patient’s medical and psychiatric assessment, including patient and carers’ concerns, risks to self or others and relevant protective factors.</td>
<td></td>
</tr>
<tr>
<td>R Giver sets out clearly the suggested or actual care plan and indicates how it addresses the patient’s and carer’s concerns</td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td>Rating (number of ‘yes’ responses out of 5)</td>
<td></td>
</tr>
</tbody>
</table>


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 systems11.

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 SA blood sector governance

Blood Organ and Tissue Programs (BOT) in SA Health is responsible for coordination of the supply planning process for blood and blood products for SA. BOT also oversees statewide policy development relating to the utilisation of these products through the SA Blood Management Council (the Council). BOT, through the Council, has oversight of clinical governance arrangements for blood product use via specialist clinical user groups and auspices the BloodSafe Program, as shown in figure 7.1.

Figure 7.1 – Governance structure for the SA Blood Sector

11 National Safety and Quality Health Service Standards (October 2012), Australian Commission on Safety and Quality in Health Care.
7.1.2 South Australian Blood Management Council

The South Australian Blood Management Council (the Council) is the peak advisory body on blood sector matters in 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, gastroenterology, haematology, haemophilia, medical, surgical, obstetrics and gynaecology, oncology, orthopaedics, paediatrics, perfusion, 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 2014-15, the Council focussed on the following key areas of activity:

- transfusion thresholds in Upper Gastro Intestinal (UGI) bleeding
- recommendations for provision of Cytomegalovirus negative blood products
- access to IV iron and review of local protocols
- transfusion education and training for staff involved in the transfusion process (including recommendations regarding completion of BloodSafe eLearning Australia Courses)
- provision of clinical input into the development of transfusion order sets in EPAS, in particular critical bleeding events and management of transfusion reactions
- engagement with the private sector
- input to the SA Stroke Guidelines
- standardisation of consent procedures and guidelines;
- prioritising patient blood management activities in the SA BloodSafe nurse work plans.

Two sub groups 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 key areas of patient blood management:

- new testing methods such as thromboelastometry (TEM) to drive transfusion practice
- cell salvage which allows collection and replacement of blood lost perioperatively
- pre-operative anaemia management
- adult iron stores optimisation pathway
- single unit red cell transfusion in specific patient groups
- warfarin reversal in intracranial haemorrhage
- specimen volume reduction.
To facilitate progression in these areas, the Council endorsed some clinical practice improvement projects. Key outcomes from selected projects in the Local Health Network's include:

> **Women’s and Children’s Health Network:**
  
  - IV iron obstetrics project with aims of reviewing the current use of IV iron products for maternity patients, evaluating the role of ferric carboxymaltose and implementing a new process for the use of this product. The change in practice to administering ferric carboxymaltose for antenatal patients has been easily adopted by midwives, medical staff and patients by establishing a specific outpatient area for women and having an easy to follow process. As a result, the management of iron deficiency anaemia in pregnancy has improved.

> **Northern Adelaide Local Health Network**
  
  - as above for the Women’s and Children’s, a nurse/midwife led peri-operative/peri-partum infusion clinic for the management of iron deficiency anaemia in pregnancy has been established.
  
  - a cell salvage education process was implemented that exposed 21 perioperative nurses to intra-operative cell salvage at the Royal Adelaide Hospital cardio-thoracic unit. Feedback from the education process was exceedingly positive.

> **Central Adelaide Local Health Network**
  
  - project to implement TEM in cardiothoracic surgery through the development of a transfusion algorithm to guide blood product use based on ROTEM® results. The process to date has included familiarisation and education of anaesthetists, perfusionists, cardiac surgeons, intensivists, haematologists and laboratory staff on the interpretation of results and their application in the clinical setting. Various measures will be used to assess the impact, including administration of fresh and non-fresh products, mortality, ventilator hours/days, length of stay – whole and in ICU, and incidence of unplanned surgical re-exploration during the hospital stay.

> **Country Health SA Local Health Network:**
  
  - project on IV iron management in iron deficiency anaemia. An IV Iron Steering Group was convened in July 2014 and meets six weekly focussing on the management of IV iron therapy in country SA.
  
  - project to implement a whole of country health Critical Bleeding guideline. This guideline was implemented along with a supporting poster to promote its uptake.

### 7.1.3 Undertaking quality improvement activities to improve the safe management of blood and blood products

In 2014-15 a BloodSafe link nurse project was instituted across Central Adelaide Local Health Network. The aim of the project was to ensure safe transfusion practice for the patient. Blood safety responsibility belongs to everyone across the clinical domain. The presence of a clinical champion, in the form of a blood and blood products portfolio nurse (PN), is beneficial for improving patient safety and facilitating change. It also provided support to improve compliance with National Safety and Quality Health Service Standard 7.

Implementation of the project included:

> the identification of 90 blood and blood products portfolio nurses across sites;

> the establishment of a governance framework to ensure awareness of the limitations of the portfolio nurse role and the overall reporting and governance structure of the Local Health Network

> the establishment of transfusion orientated key performance indicators to support the role’s structure and development

> an initial one day training on transfusion processes, safety and risk and role expectation to support the portfolio nurses

> the provision of ongoing support tools and resources.
Results of practice change and safety improvement included:

- 88% of PN’s reported the role had changed their own transfusion practice
- 84% of PN’s reported the role had changed transfusion practice in their clinical area
- 89% of peers found the role beneficial for the clinical area
- 76% of PN’s had supported accreditation requirements with auditing activity
- 100% of PN respondents who had completed the simulated ‘Pack Check’ audit found it worthwhile and a prompt for education points within their area.
- 68% of PN staff who had completed the auditing found the audit process was a catalyst to improve patient safety.

At 12 months the program had showed a ripple effect of practice improvement. Results demonstrate that portfolio nurse education is effective; there is an increased awareness of correct practice, the importance of haemovigilance reporting and activity; improved transfusion knowledge and improved engagement in the clinical domain. The program is now being developed for implementation across the state.

7.1.4 Improving consistency of policies, procedures and protocols with national guidelines

BloodSafe have developed Quick Reference Guides reflecting national Patient Blood Management guidelines to assist clinicians prescribe red cell transfusions appropriately:

- The Quick Reference Guide: Guidance on Red Cell Transfusion Practice (see item 23)

The BloodSafe Quick Reference Guide – Guidance on Red Cell Transfusion Practice was issued to new interns and medical staff at the beginning of the year. These were very well received and a further reprint was required.


## 7. Blood and blood products

### 7.1.5 Blood utilisation patterns

In Australia, blood is freely donated and then distributed by the Blood Service to public and private hospitals and pathology laboratories. A number of strategies and key activities are in place to both improve blood utilisation and reduce unnecessary wastage. Utilisation patterns are well known within the SA public sector, in terms of key clinical specialties utilising red cells, and overall wastage levels are well documented. However, the path red cells taken from their original issue to their final fate has not been fully studied before.

During 2014-15, an exercise was undertaken to follow and document the ‘tour of duty’ that red cells take across the blood sector in South Australia. Blood and blood products are ordered through an information system called BloodNet, which is a national web-based system that allows health providers across Australia to order blood and blood products in a standardised way, quickly, easily and securely from the Blood Service.

Data for 2012-13 was studied, which showed that nearly all units issued from the public transfusion laboratories could be tracked through the BloodNet and laboratory information systems to their final fate. This confirms the utility of current database systems in place for monitoring blood and blood product issues.

A large number of near expiry red cells, particularly O negative red cells, were transferred from the regional to metropolitan laboratories and from smaller to larger metropolitan laboratories through the BloodMove program (picture 26) and achieved a 94% success rate in being transfused. Such information can help inform the necessary partnering of regional hospitals with both regional and metropolitan laboratories and hospitals to minimise unnecessary discards and maintain adequate inventory levels.

**Picture 26: Summary of red cell unit issues and transfers to SA public and private laboratories**

<table>
<thead>
<tr>
<th>Metro Private Labs</th>
<th>Metro Public Hospital Labs</th>
<th>Regional Public Hospital Labs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbott Pathology</td>
<td>Flinders Medical Centre</td>
<td>Berri</td>
</tr>
<tr>
<td>Adelaide Pathology Partners</td>
<td>Lyell McEwin Hospital</td>
<td>Gawler</td>
</tr>
<tr>
<td>Clinpath</td>
<td>Modbury Hospital</td>
<td>Mt Gambier</td>
</tr>
<tr>
<td>Healthscope</td>
<td>Royal Adelaide Hospital</td>
<td>Pt Augusta</td>
</tr>
<tr>
<td></td>
<td>The Queen Elizabeth Hospital</td>
<td>Pt Lincoln</td>
</tr>
<tr>
<td></td>
<td>Noarlunga Hospital</td>
<td>Pt Pirie</td>
</tr>
<tr>
<td></td>
<td>Women’s and Children’s Hospital</td>
<td>Victor Harbor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wallaroo</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Whyalla</td>
</tr>
</tbody>
</table>

Blood Service Issues

Red cells (66759), Irradiated (19%), CMV Neg (31%)

<table>
<thead>
<tr>
<th>Issued</th>
<th>Transferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>(16790 units issued)</td>
<td>1275 units transferred</td>
</tr>
<tr>
<td>(42678 units issued)</td>
<td>3938 units transferred</td>
</tr>
<tr>
<td>(7291 units issued)</td>
<td>3938 units transferred</td>
</tr>
</tbody>
</table>
7.1.6 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 South Australia, the program now attracts joint national funding with the current contract approved to March 2016. 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)
- patient blood management (general course)
- critical bleeding (based on module 1 of the national Patient Blood Management Guidelines)
- perioperative (based on module 2 of the national Patient Blood Management Guidelines)
- medical course (based on module 3 of the national Patient Blood Management Guidelines) and five specialty courses that complement and add to the basic medical course (cancer, cardiac, chronic kidney disease, chronic transfusion and gastroenterology).

The suite of 14 courses has proven to be very popular with an average of 14600 course completions per month and over 500000 course completions across Australia. South Australia has one of the highest rates of use with 8.7% registered users nationally accounting for over 13% of course completions. BloodSafe eLearning Australia continues to review and improve the courses based on feedback to ensure continuous improvement of the clinical education.
Achievements by BloodSafe eLearning Australia during 2014-15:

- Release of six new courses based on the National Patient Blood Management guidelines: Module 3 Medical.
- Conversion of all courses to be mobile device friendly.
- New database and system with improved reporting and learner tracking.
- Review and update of the Iron Deficiency Anaemia course content.
- Design and development of a new website (see picture 28).

Picture 28: BloodSafe eLearning Australia new website homepage
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.

Audits of consent during 2014-15 included:

> a haematology inpatient red cell audit of consent at the Queen Elizabeth Hospital found the documented consent rate to be 80%
> development of an Intensive Care Unit (ICU) consent process at the Royal Adelaide Hospital which incorporates blood and blood products. Consent compliance in the ICU improved from 56% to 63% as a result
> audits of consent to red cell transfusion conducted at the Women’s and Children’s Hospital in the Paediatric Division (72%) and the Delivery Suite (95%).

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 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. South Australia 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 2014-15 are shown in graph 17.

Graph 17: Incidents relating to transfusion of blood and blood products 2014-15

Source: Safety Learning System

7.3.2 BloodMove

The Country Health SA Local Health Network (CHSALHN) BloodMove project oversees 65 hospitals in country SA and continues to be a major initiative in 2014-15. It is managed and facilitated by a team which consists of one medical scientist lead, one nurse management facilitator lead and six regional Director of Nursing and Midwifery (DONM) leads and eight regional BloodSafe clinical nurses. This team is further supported by a designated contact nurse for each hospital.

Key highlights for 2014-15 include:

- Completion of funded projects via the South Australian Blood Management Council (refer section 7.1.1).
- Implementation of a whole of country Blood and Blood Products Inventory Manual in October 2014. The manual provides guidance to all country SA regional, rural and remote health services on the appropriate storage, transportation, inventory management and minimisation of wastage of blood and blood products.
- BloodMove was invited to present talks and posters at the following conferences:
  - Haematology Society of Australian and New Zealand (HSANZ) Education Day, Adelaide, September 2013
  - Australian College Health Service Management Congress, Adelaide, September 2014
- The release of the Critical Bleeding Management Guideline included a reassessment of emergency blood and blood product stock holdings at country sites. This resulted in stock holding increases at appropriate sites of Prothrombinex and red cells. Six new blood fridges were also purchased, commissioned and installed during 2014-15.
- The BloodMove program won the national 2014 Australian Council Healthcare Standards (ACHS) Award for Non-Clinical Service Delivery and the inaugural National Blood Management Award for Excellence in a Public/Private Health Sector Collaboration.
7.3.3 **BloodMove platelet project**

Blood product wastage minimisation is a national stewardship obligation for all transfusion laboratories and hospitals which requires conscientious efforts to achieve this goal. Platelet inventory management and wastage minimisation forms part of this stewardship and poses significant challenges. Platelet wastage is almost exclusively due to product expiry and difficult to minimise primarily because of the short product expiry times.

**BloodMove Platelets** is a platelet wastage minimisation project involving collaboration between the SA Health Blood, Organ and Tissues Program Unit, metropolitan SA Pathology and private pathology transfusion service laboratories. The aim of the project was to minimise platelet wastage due to expiry. The historical acceptance that high wastage due to short platelet expiry could not be avoided was deemed no longer tolerable.

The **BloodMove Platelet** project was implemented in a staged manner during 2014-15. Initial planning included auditing inventory levels, platelet usage and wastage patterns across all metropolitan public hospitals. Strategies to minimise platelet wastage included transfer of near expiry platelets to large metropolitan laboratories, establishment of a common shared near expiry platelet listing for use by all Adelaide metropolitan SA pathology and private laboratories in preference to the use of available fresher platelets or by placing a Red Cross Blood Service BloodNet order and finally by adjusting platelet inventories.

Within the first month of operation, BloodMove Platelets achieved a significant drop in platelet wastage for metropolitan public hospitals, from a typical 21.5% in July 2014 to 10.7% in August 2014. This decrease has been sustained with an average discard rate of 7.7% [95% Confidence Interval (CI) 7.1- 8.3]. The average number of platelets discarded per month is now 57 compared to 130 prior to the project, a decrease in discard of 56% (Graph 18).

**Graph 18: Platelet packs discarded per month for metropolitan Adelaide public**

![Graph showing platelet packs discarded per month for metropolitan Adelaide public](source: BloodNet)
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 Informed consent

In order to enable patients to be informed about the risks and benefits of a blood transfusion, and possible alternatives, the development and dissemination of information for patients relating to blood and blood products is required. Central Adelaide Local Health Network (CALHN) implemented a Consent to Blood Transfusion/Blood Product Administration Form which incorporates the ‘BloodSafe Quick Reference Guide: Obtaining Informed Consent for Blood and Blood Products’ and importantly a transfusion information sheet ‘Receiving a blood transfusion: Important information’ as a tear off fact sheet. The form had been previously developed and introduced throughout CHSA. Other LHNs are considering using this intervention which would mean standardisation across the sector ensuring compliance with National Safety and Quality Health Service Standard 7.

7.4.2 BloodSafe website

The BloodSafe website has a range of materials for patients related to blood transfusion, consent for transfusion, iron therapy and children receiving transfusions. These can be accessed by the general public, or used by clinicians to help inform their patients of the risks and benefits of using blood and blood products, where applicable. The BloodSafe website can be found at www.sahealth.sa.gov.au/bloodsafe.

A dedicated section on the website has been created on iron disorders. This includes a list of resources for consumers in multiple languages related to both anaemia and iron deficiency. The resources are also being used by clinic staff to assemble patient information displays (picture 29).

Picture 29: Multi-lingual patient BloodSafe brochures on boosting your blood with iron
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\textsuperscript{12}.

National Safety and Quality Health Service Standard 8 – Preventing and managing pressure injuries includes\textsuperscript{13}:

\begin{itemize}
  \item governance and systems for the prevention and management of pressure injuries
  \item preventing pressure injuries
  \item managing pressure injuries
  \item communicating with patients and carers.
\end{itemize}

There is good evidence about best practice for prevention, and also for wound care that promotes optimal healing. Care delivered by SA Health services is guided by the best practice guidelines Prevention and Treatment of Pressure Ulcers: Clinical Practice guideline 2014 (National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance).

\section*{8.1 Governance and systems for the prevention and management of pressure injuries}

\subsection*{8.1.1 Policy and governance}

The SA Health Prevention and management of pressure injuries clinical policy directive and guideline is available on the SA Health website Preventing and managing pressure injuries page at www.sahealth.sa.gov.au/safetyandquality.

Each Local Health Network has a system of committees that plan and coordinate activities, and report to executive level, around pressure injury prevention, wound management and other skin integrity issues. An example of the terms of reference, roles and functions for local committee is available. This illustrates how an effective committee can be a key driver for implementing best practice and demonstrating that standards are met.

In 2014-15, all SA Health services that have been surveyed against National Safety and Quality Health Service Standard 8, have met the accreditation requirements. There is considerable work ongoing in each LHN to develop systems and gather evidence of the shift in practice towards that recommended by the best practice guidelines, in order to meet the requirements of Standard 8.
Case study:

Central Adelaide Local Health Network point prevalence audit

On Thursday 20 November 2014, International Day for the Prevention of Pressure Injuries, Central Adelaide Local Health Network (CALHN) undertook a point prevalence audit as part of the NSQHS Standard 8 – Skin Integrity and Pressure Injury Prevention and Management.

All individuals present across CALHN, including the Emergency Departments but excluding Mental Health, Palliative Care and outpatient areas, were surveyed.

Surveyors included nurses with portfolios of pressure injury prevention, Skin Wound Assessment Team (SWAT) nurses, senior nursing staff and nursing directors. Education was provided to all surveyors regarding obtaining consent, documentation to expect and how to do the skin inspection. The survey examined all patient medical records and documentation, a comprehensive skin inspection and questions to the patient or family/carer.

Analysis of the results indicated the need for improvement in the following areas: undertaking and documenting comprehensive skin inspections for patient's/client's at risk of pressure injuries; taking action to increase skin assessments for patients/clients at risk of pressure injuries; involving patients/clients and carers in pressure injury management plans, preventing hospital acquired pressure injuries; and case note documentation of SLS reporting.

However the audit also identified significant improvements. Since the 2013 survey:

- the proportion of patients/clients having a pressure injury risk assessment within eight hours improved by 7%
- 34% of patients/clients reported receiving information on prevention and management of pressure injuries in a format that was meaningful and understood, an improvement of 44%
- 45% of patients/clients were involved in their pressure injury prevention plan, an improvement of 3%.

In June 2015, there are now 139 nurses trained in SWAT with a CALHN goal to have a minimum of two nurses per clinical area or ward educating their peers and leading the way in pressure injury prevention care for patients.

The survey will be repeated on 19 November 2015.
8. Preventing and managing pressure injuries

8.1.2 Pressure injury incidents during care

Reporting pressure injuries as a specific incident type into Safety Learning System (SLS) is still relatively new and the reporting culture continues to develop.

In 2012-13 there were 461 reports of pressure injury into SLS, 1333 reports in 2013-14 and, in 2014-15 that has increased to 2380 incidents. The majority of all pressure injuries this year were rated SAC 3 or SAC 4 (99%).

There were 2102 pressure injuries reported in 2014-15 that were either newly acquired during an episode of health care (54.9%); or deteriorated or worsened during the admission or an internal transfer between SA Health services (33.4%). The prevalence of the latter reinforces the importance of including pressure risk and prevention routinely in handover.

Table 22 indicates that 278 (11.7%) pressure injuries were present when the person was first admitted to an SA Health service in 2014-15. These are not incidents related to care provided by SA Health, and staff are not required to report these into SLS. Data is used by services to indicate the total demand on services and wound specialists.

<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>1307</td>
<td>54.9%</td>
</tr>
<tr>
<td>Worsening of existing/observed after internal transfer</td>
<td>795</td>
<td>33.4%</td>
</tr>
<tr>
<td>Present on admission from home or external service provider</td>
<td>278</td>
<td>11.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2380</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

The capabilities of the SLS to provide rich, clinically relevant information are being realised.

Over half (55%) of all reports included information about the number of pressure injuries on the person.

Of these 65% reported only one, 22% reported two, and the remaining 13% 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). This information indicates that 81.1% were Stage 1 or 2, which is the least severe (table 23).

Table 23: Stage of the pressure injury 2014-15

<table>
<thead>
<tr>
<th>Stage of the pressure injury</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>847</td>
<td>35.6%</td>
</tr>
<tr>
<td>Stage 2</td>
<td>1082</td>
<td>45.5%</td>
</tr>
<tr>
<td>Stage 3</td>
<td>112</td>
<td>4.7%</td>
</tr>
<tr>
<td>Stage 4</td>
<td>40</td>
<td>1.7%</td>
</tr>
<tr>
<td>Unstageable</td>
<td>140</td>
<td>5.9%</td>
</tr>
<tr>
<td>Not known</td>
<td>122</td>
<td>5.1%</td>
</tr>
<tr>
<td>Suspected deep</td>
<td>37</td>
<td>1.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2380</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System
Pressure injuries are discussed with patient, families and carers over 75% of the time (Open disclosure section table 12).

Table 24 demonstrates that, although more numerous, pressure injuries that develop during an admission tend to be less deep and less serious than those that are present on admission. 87.1% of new pressure injuries were stage 1 or 2 when reported. It is possible that new pressure injuries are identified earlier.

Table 24: Percentage of pressure injury by stage and whether the injury was present on admission, acquired during care or worsening

<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>44.3%</td>
<td>26.0%</td>
<td>24.6%</td>
</tr>
<tr>
<td>Stage 2</td>
<td>42.8%</td>
<td>48.7%</td>
<td>48.7%</td>
</tr>
<tr>
<td>Stage 3, 4, unstageable, suspected deep</td>
<td>8.0%</td>
<td>19.5%</td>
<td>21.7%</td>
</tr>
<tr>
<td>Not known</td>
<td>4.9%</td>
<td>5.8%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

Data from the additional (optional) questions in SLS about all pressure injuries were analysed.

The question ‘Patient factors contributing to pressure injury’ was completed for 1583 incidents (66% of all 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 approximately 30% of reports (table 25).

Table 25: Patient factors contributing to pressure injury

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number</th>
<th>% of reports where this was selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired mobility</td>
<td>1125</td>
<td>71.1%</td>
</tr>
<tr>
<td>Low levels of activity</td>
<td>880</td>
<td>55.6%</td>
</tr>
<tr>
<td>Poor nutritional status/malnutrition</td>
<td>587</td>
<td>37.1%</td>
</tr>
<tr>
<td>Underweight or obese</td>
<td>480</td>
<td>30.3%</td>
</tr>
<tr>
<td>Impaired body sensation</td>
<td>472</td>
<td>29.8%</td>
</tr>
<tr>
<td>Difficulty complying with prevention strategies</td>
<td>323</td>
<td>20.4%</td>
</tr>
<tr>
<td>Impaired circulation or perfusion</td>
<td>320</td>
<td>20.2%</td>
</tr>
<tr>
<td>Palliative, frail</td>
<td>302</td>
<td>19.1%</td>
</tr>
<tr>
<td>Oedema, swelling</td>
<td>220</td>
<td>13.9%</td>
</tr>
<tr>
<td>Long period of anaesthesia or sedation</td>
<td>107</td>
<td>6.8%</td>
</tr>
<tr>
<td>History of pressure injury(s) in the last two years</td>
<td>202</td>
<td>12.8%</td>
</tr>
<tr>
<td>Rash, dermatological condition(s)</td>
<td>60</td>
<td>3.8%</td>
</tr>
<tr>
<td>None of the above</td>
<td>62</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System
The question ‘Environmental factors contributing to pressure injury’ was completed for 1512 incident reports (64%). An average of 2.1 environmental factors was selected per incident. Exposure to pressure was reported most commonly (75%). Friction, shearing forces and moisture were all identified as a contributing factor in over 30% of reports.

Devices in contact with skin were implicated in 15% of reports, and this has decreased since 2013-14 when this was over 20%. Devices include tubing, splinting materials and anti-embolic stockings.

Table 26: Environmental factors contributing to pressure injury

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number</th>
<th>% of reports where this was selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure to pressure</td>
<td>1136</td>
<td>75.1%</td>
</tr>
<tr>
<td>Exposure to friction</td>
<td>570</td>
<td>37.7%</td>
</tr>
<tr>
<td>Exposure to shearing forces</td>
<td>476</td>
<td>31.5%</td>
</tr>
<tr>
<td>Exposure to moisture</td>
<td>475</td>
<td>31.4%</td>
</tr>
<tr>
<td>Presence of device(s) in contact with skin</td>
<td>223</td>
<td>14.7%</td>
</tr>
<tr>
<td>Exposure to poor hygiene/skin irritants</td>
<td>198</td>
<td>13.1%</td>
</tr>
<tr>
<td>Exposure to high skin temperatures</td>
<td>65</td>
<td>4.3%</td>
</tr>
<tr>
<td>None of the above</td>
<td>74</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System
8.2 Preventing pressure injuries

8.2.1 Screening, assessment and care-planning

Two medical records forms, the Pressure injury Risk assessment form (MR95), and the Pressure Injury Prevention Plan (MR95A) were finalised in 2014, and were implemented in 2014-15.

In collaboration with clinical experts, modifications to the skin screening and assessment components of EPAS have been recommended. The forms will assist health services to meet the requirements of National Safety and Quality Health Service Standard 8 for a comprehensive assessment that includes screening and skin and pain assessment.

Picture 30: Pressure Injury Prevention Plan (MR95A) form
8. Preventing and managing pressure injuries

8.3 Managing pressure injuries
Following the release, copies of the new international best practice guidelines Prevention and Treatment of Pressure Ulcers: Clinical Practice guideline (National Pressure Ulcer Advisory Panel [NPUAP], European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance, 2014), were delivered to each LHN committee.

Case study:
Northern Adelaide Local Health Network pressure injury prevalence audit
The Northern Adelaide Local Health Network undertook a full organisational wide Pressure Injury (PI) prevalence audit during February 2015. On a single day 458 patients were audited within Lyell McEwin Hospital, Modbury Hospital and Older Persons Mental Health Inpatient Services.

Four audit tools were developed for the different patients groups across NALHN Adult, Obstetric, Paediatric and Neonatal. The audit consisted of three sections:

> demographic section including ward/unit and auditor details
> medical record documentation review including the bedside notes
> bedside selection which included questions to ask the patient and undertake a skin inspection.

Participation in the audit was voluntary. 75% of patients who were asked to participate in the audit consented to a head to toe skin inspection.

There were 51 pressure ulcers identified from 458 patients, which is an 11% prevalence rate. This is comparable with other similar studies. In 2006, Victoria Health reported an overall Pressure Injury (PI) prevalence of 11.9%. Nevada US cited an average PI prevalence of 10% in their acute hospitals. Two Swedish county councils found PI prevalence of 7.7% and 11.3%.

This audit provided the opportunity for clinicians to increase their knowledge and skills in identifying and classifying pressure injuries as per the Australian Wound Management Association (AWMA) Guidelines.

As a result of the PI Prevalence Audit, awareness was raised about competing timely assessments to identify risk factors and prevent pressure injuries.

8.4 Communicating with patients and carers
SA Health services participated in international Stop Pressure Ulcer Day in November by holding activities for staff and consumers.

SA Health consumer fact sheet ‘Preventing pressure injuries’ is available on Preventing and managing pressure injuries page.

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 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 data indicates that the monitoring and assessment of patients is the major area in which to focus improvements.
### Table 27: Recognition and response related incidents by level 3 classification and results 2014-15

<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>2</td>
<td>355</td>
<td>599</td>
<td>55</td>
<td>1012</td>
</tr>
<tr>
<td>Lack of clinical assessment</td>
<td>3</td>
<td>5</td>
<td>256</td>
<td>496</td>
<td>45</td>
<td>805</td>
</tr>
<tr>
<td>Other incident to do with assessment</td>
<td>1</td>
<td>3</td>
<td>142</td>
<td>250</td>
<td>26</td>
<td>422</td>
</tr>
<tr>
<td>Failure to follow up</td>
<td>0</td>
<td>1</td>
<td>87</td>
<td>151</td>
<td>16</td>
<td>255</td>
</tr>
<tr>
<td>Delay/difficulty in obtaining clinical assistance</td>
<td>2</td>
<td>3</td>
<td>86</td>
<td>113</td>
<td>7</td>
<td>211</td>
</tr>
<tr>
<td>Delay in diagnosis</td>
<td>3</td>
<td>11</td>
<td>76</td>
<td>76</td>
<td>17</td>
<td>183</td>
</tr>
<tr>
<td>Failure/delay to order correct tests, image etc</td>
<td>0</td>
<td>1</td>
<td>37</td>
<td>57</td>
<td>2</td>
<td>97</td>
</tr>
<tr>
<td>Failure to act on adverse symptoms</td>
<td>0</td>
<td>4</td>
<td>50</td>
<td>16</td>
<td>4</td>
<td>74</td>
</tr>
<tr>
<td>Delay/failure in acting on complication of treatment</td>
<td>1</td>
<td>3</td>
<td>33</td>
<td>17</td>
<td>2</td>
<td>56</td>
</tr>
<tr>
<td>Patient risk/deterioration not communicated</td>
<td>0</td>
<td>0</td>
<td>24</td>
<td>18</td>
<td>3</td>
<td>45</td>
</tr>
<tr>
<td>Unplanned admission/transfer to specialist care unit</td>
<td>0</td>
<td>1</td>
<td>15</td>
<td>19</td>
<td>2</td>
<td>37</td>
</tr>
<tr>
<td>Failure to act on adverse test results or images</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>19</td>
<td>1</td>
<td>34</td>
</tr>
<tr>
<td>Cardiac arrest</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Respiratory arrest</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12</td>
<td>36</td>
<td>1178</td>
<td>1833</td>
<td>182</td>
<td>3241</td>
</tr>
<tr>
<td><strong>%</strong></td>
<td>0.4%</td>
<td>1.1%</td>
<td>36.3%</td>
<td>56.6%</td>
<td>5.6%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

#### 9.1.1 Establishing recognition and response systems

**9.1.1.1 Rapid Detection and Response (RDR) observation charts**

The Rapid Detection and Response Charts, designed to improve the detection and response to clinical deterioration, are now in their second year of use in all acute health care settings. Variations of the RDR observation charts have been made to adapt to the context of clinical areas such as the emergency department. Work continues on new adaptations for use in renal dialysis units, prison health, rural emergency departments, paediatric emergency, and for neonates. The embedding of the RDR Chart into the Enterprise-wide Patient Administration System (EPAS) provides a method for measuring the effectiveness of recognition and response systems, and to identify areas for improvement.

#### 9.1.2 Communication with patients, families and carers in recognition and response systems

If a patient’s condition deteriorates, the health care team need to know what care and treatment the patient may or may not want. At the time of deterioration, a patient may be too unwell to be able to participate in decision-making about their health. Easily accessible contact details for the patient’s loved ones are important for clinicians in this circumstance. SA Health systems are being re-designed to record and have ready access to the name and contact details of the person(s) legally able to make health care decisions on a patient’s behalf, in accordance with the introduction of the *Advance Care Directives Act 2013* and the amendments to the *Consent to Medical Treatment and Palliative Care Act 1995*. 
Help us help you – Essential contacts was reviewed and endorsed by the SA Health Safety and Quality Consumer and Community Advisory Group and provides consumers with information to guide them in considering the correct contact details to provide when presenting to a health service. SA Health employees are being trained to ask for the essential contacts and record details in patient administration systems. These practices will facilitate obtaining correct information in advance of any patient deterioration, in order to minimise the risk of clinical decision-making that does not align with a patient’s wishes, at the time of deterioration.

Item 24: Help us, help you – Essential contacts information sheet

9.1.3 Advance Care Directives

Advance Care Directives (ACD) guide the clinician in providing care a person would want in the event the person may be too unwell or unable to make their own decisions. A person may plan ahead and write their wishes, preferences and instructions for future health care, end-of-life care, living arrangements and personal matters in an Advance Care Directive. They may also use an Advance Care Directive to appoint one or more Substitute Decision-Makers to make decisions on their behalf in future, if they are unable to do so.

Processes and systems across SA Health are being designed in a standard way to ensure that if a person presents to an SA Health service with an Advance Care Directive, it will be readily accessible to clinicians who may require it for person-centred care planning. In addition, SA Ambulance officers and paramedics are trained to seek Advance Care Directives or other documentation that may provide instruction for a person’s health care wishes, where possible.
Train the Trainer Workshops for over 350 senior SA health employees and other training sessions within SA Health, Residential Aged Care providers, and General Practitioners have been conducted to provide them with the knowledge and resources to educate others in their roles and responsibilities in relation to Advance care Directives, Consent and Resuscitation Planning. Collaboration has been key in implementation of Advance Care Directives and has included organisations such as Residential Aged Care Providers, the Royal Australasian College of General Practitioners NT/SA, the Health Consumers Alliance SA, the Legal Services Commission, the Office of the Public Advocate, SA Universities, and non government organisations.

Training materials and over 30 resources and 13 videos have been produced and are available on the Advance Care Directives page on the SA Health website at www.sahealth.sa.gov.au

Picture 31: A clear path to care – Advance Care Directives training video

Recognition that a person is at the end-of-life and decisions about care during this time can be difficult for patients, families and carers, as well as clinicians. Timely, sensitive discussions about a person’s goals, needs and preferences are key to high quality, end-of-life care and facilitate the person dying with comfort and dignity. Wherever possible, urgent decisions about resuscitation and life-saving treatment should not be made when a person at end-of-life is deteriorating and their condition triggers an emergency response for resuscitation.

The SA Health Resuscitaton Plan - 7 Step Pathway provides a best practice approach for engaging patients in shared decision-making for resuscitation and end-of-life care planning. It is a clinical plan that provides instructions for clinical care based upon the goals, preferences, and needs expressed by a person either directly or through their Advance Care Directive, Advance Care Plan, Substitute Decision-Maker/s or Person Responsible.

The Health Consumers Alliance SA conducted a Rescusitation Plan – 7 Step Pathway Forum and provided valuable input into the drafting of policy and demonstrated strong support for the implementation of the Resuscitation Plan - 7 Step Pathway process. Consumers are central to the purpose and design of this important improvement process for safe, high quality end-of-life care.
The Northern Adelaide Local Health Network was a pilot site in the implementation of the Resuscitation Plan - 7 Step Pathway and have continued to adopt its use across their health services. The model for implementing the program ensured leadership and mentorship by a highly qualified medical practitioner, clinician education, design of systems, processes, and procedures, engagement with external stakeholders, and evaluation.

Initial results demonstrate that improving resuscitation planning using the Resuscitation Plan -7 Step Pathway process resulted in fewer medical emergency responses for patients who were at end-of-life and dying. This means that more patients were involved in resuscitation planning in advance of deterioration and had their wishes and needs respected by receiving palliative measures rather than unwanted resuscitation or intensive care treatment. Evaluation of the quality of the care planning is currently underway.

Graph 19: MER calls where direct terminal care was provided, as identified by MER Coordinator 2012-15

The data shows a reduction in Medical Emergency Response (MER) Calls for a period of more than a year and is sustained.

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

10 Preventing falls and harm from falls
10. Preventing falls and harm from falls

Falls are a significant cause of potentially avoidable harm. Older people are most affected. As falls are the most frequently reported incident type, and the SA population ages, the need for effective systems to identify who is at risk, and to provide high quality care is increasing.

National Safety and Quality Health Service Standard 10 – Preventing falls and harm from falls 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.

There is strong evidence that many falls are preventable. Care delivered by SA Health services is guided by 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, 2009).

10.1 Governance and systems for the prevention of falls

10.1.1 Governance

The SA Health Fall and fall injury prevention and management policy directive, guideline and tools are undergoing scheduled revision, due for completion later in 2015.

The Preventing falls and harm from falls page on the Safety and Quality section of the SA Health website at www.sahealth.sa.gov.au/safetyandquality has been revised in 2014-15 to reflect the addition of new and revised resources.

In 2014-15, all SA Health services that have been surveyed against Standard 10, have met the requirements. There is considerable work ongoing in each LHN to develop systems and gather evidence of the shift in practice towards that recommended by the best practice guidelines.

Each Local Health Network has a system of committees that plan and coordinate activities, and report to executive level. An example of the terms of reference, roles and functions for a local committee illustrates how an effective committee can be a key driver for implementing best practice and demonstrating that standards are met. The terms of reference is available on the Safety and Quality webpage.

10.1.2 Fall incidents during care

Under the Primary Incident Classification (Table 8) patient falls and other injuries is the most common incident type with 12245 incidents. This classification includes 1780 other patient injuries such as collisions, lifting or sharps incidents and exposure to hazardous substances. Those are excluded from the following discussion.

In 2014-15, 10465 falls incidents, of which nearly 800 were classified as near misses.

Despite the number of reports of falls incidents rising each year, both the number and proportion that are harmful (rated SAC 1 or SAC 2) continues to decline, from 2.9% (n=210) in 2011-12 to 1.4% (n=143), in 2014-15.

14 National Safety and Quality Health Service Standards (September 2011), Australian Commission on Safety and Quality in Health Care
Table 28: Falls incidents reported by SAC codes 2010-14

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SAC 1</td>
<td>48</td>
<td>22</td>
<td>26</td>
<td>16</td>
</tr>
<tr>
<td>SAC 2</td>
<td>162</td>
<td>153</td>
<td>118</td>
<td>127</td>
</tr>
<tr>
<td>SAC 3</td>
<td>4215</td>
<td>4626</td>
<td>4987</td>
<td>4798</td>
</tr>
<tr>
<td>SAC 4</td>
<td>2767</td>
<td>3421</td>
<td>4397</td>
<td>5294</td>
</tr>
<tr>
<td>Uncoded incidents</td>
<td>165</td>
<td>191</td>
<td>197</td>
<td>230</td>
</tr>
<tr>
<td>Total</td>
<td>7357</td>
<td>8413</td>
<td>9725</td>
<td>10465</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

Notifiers are asked to report if there was harm to the individual or the organisation. Of these, 31.2% indicate that there was harm. The degree of harm varies, and 81.3% were skin tears, bruises, pain or abrasions.

Reports of the site of the injuries indicates that 30.4% of injuries are to the head, 37.7% upper limb and 27.1% lower limb. Injury to the head is important because of the need to monitor for intracerebral bleeds, especially for older patients who are taking anticoagulant therapy.

The circumstances in which falls occur, particularly harmful falls, is sometimes unknown because only 28% 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 29: Most frequent activities at the time of fall 2014-15

<table>
<thead>
<tr>
<th>Most frequent activities at the time of fall 2014-15</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>443</td>
<td>1018</td>
<td>95</td>
<td>1556</td>
</tr>
<tr>
<td>Walking</td>
<td>637</td>
<td>835</td>
<td>115</td>
<td>1587</td>
</tr>
<tr>
<td>Getting in/out of bed</td>
<td>354</td>
<td>733</td>
<td>86</td>
<td>1173</td>
</tr>
<tr>
<td>Toileting, or attempting to toilet</td>
<td>347</td>
<td>457</td>
<td>43</td>
<td>847</td>
</tr>
<tr>
<td>Bending/leaning/reaching over</td>
<td>222</td>
<td>441</td>
<td>43</td>
<td>706</td>
</tr>
<tr>
<td>Standing</td>
<td>153</td>
<td>303</td>
<td>35</td>
<td>491</td>
</tr>
<tr>
<td>Sitting</td>
<td>91</td>
<td>238</td>
<td>32</td>
<td>361</td>
</tr>
<tr>
<td>Rolling on bed</td>
<td>69</td>
<td>182</td>
<td>9</td>
<td>260</td>
</tr>
<tr>
<td>Climbing over/around bedrails</td>
<td>76</td>
<td>128</td>
<td>13</td>
<td>217</td>
</tr>
<tr>
<td>Showering</td>
<td>45</td>
<td>74</td>
<td>11</td>
<td>130</td>
</tr>
<tr>
<td>Total</td>
<td>2437</td>
<td>4409</td>
<td>482</td>
<td>7328</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
Screening and assessment protocols have been reviewed in 2014-15, and there are some modifications approved for specific settings that maintain clinical efficacy, meet requirements of Standard 10 and are time efficient for staff. These will be released with the revised Falls and fall injury prevention and management policy directive and toolkit.

In 2014-15, the medical records form MR58b Falls Risk Screen was built into EPAS in the section for emergency departments. This tool was designed for emergency departments, and is recommended for use in outpatient and ambulatory clinics, day procedure services and other sites where a quick screening process is required. It is also used in some pre-admission clinics.

A review of the falls risk screening and risk review in EPAS resulted in recommended changes that will be incorporated into the next version of EPAS. The Falls prevention and management online eLearning course includes a video of the screening process.

Picture 32: Falls risk screen in the online eLearning course

### Falls risk screen
A screen is completed in the emergency department for all adults over 65; and for younger patients at high risk, or who are from high risk groups, including Aboriginal and Torres Strait Islanders over the age of 50 years.

Mrs Fuller is over 65 years of age, so she requires screening on presentation to the emergency department.

The falls risk screen is the minimum process for identifying people who are at risk of falling. It is used to determine a ‘risk score’ and create an ‘immediate falls prevention plan’.

It is also used to recommend actions to take, such as referral, if the consumer is being discharged.

10.3 Preventing falls and harm from falling
Clinical intervention is guided by the national best practice guidelines for preventing falls in Australian hospitals, community care and residential aged care (Australian Commission for Safety and Quality in Health Care).

10.3.1 Falls prevention and management education and training
A health workforce with skills, knowledge and understanding is required to deliver effective falls prevention.

> From July 2015, the Safety and Quality Unit has handed responsibility for training Falls Prevention Leaders to the LHNS, having trained over 500 Falls Prevention Leaders across SA. The Safety and Quality Unit has an ongoing role in supporting a community of practice comprising Falls Prevention Leaders and Falls Committees, through regular newsletters and other communication.

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.

> The Falls Prevention and Management online eLearning course was launched in April 2014. During 2014-15, 4836 staff completed this course, a total since launch of 8573. The online eLearning course is very practical and includes information and videos of care planning, and interventions such as safe use and assistance with walking aids.
In the event of a fall, the course describes the actions required, including post fall team review.

Picture 34.: Falls prevention and management eLearning course – post fall actions
10.4 Communicating with patients and carers

10.4.1 Consumer fact sheets

All consumer fact sheets were revised, to ensure that language and messages are clear and contact information updated. Consumer groups and clinicians provided feedback into this process.

The Falls and Fall Injury Prevention Fact Sheets were reviewed and endorsed by the SA Health Partnering with Consumers and Community Advisory Group in March 2015.

The consumer fact sheets provide information about falls prevention for members of the community including:

- Strong muscles and bones – fact sheet 1
- Eyesight and walking – fact sheet 2
- Medicines and balances – fact sheet 3
- Dizziness and balance – fact sheet 4
- Keeping safe and independent in hospital – fact sheet 5
- Comfy feet go a long way – fact sheet 6
- Standing up to falls – fact sheet 7
- Making your home your haven – fact sheet 8
- Strong and steady – fact sheet 9
- New mums and bub can fall too – fact sheet 10

Item 25: Strong muscles and bones – fact sheet 1 and Eyes and walking – fact sheet 2
10.4.2 April Falls Awareness Month

The April Falls Awareness month activities continue to build staff and the community’s understanding of falls prevention messages and services. Across SA, health services held a range of activities for their consumers and workers, including displays and staff education events.

With assistance from SA Health Media and Communications Branch, several articles were published in print, online and through social media.

Materials produced for 2015 included posters and a range of translated consumer information sheets.

Picture 35: Examples of consumer information including translated fact sheets

Resources including the consumer fact sheets, self screen checklists and posters are available on the Information for consumers on falls and fall injury prevention web page of the Safety and Quality section of the SA Health website at www.sahealth.sa.gov.au/safetyandquality.
10.4.3 Falls prevention and management online eLearning course
The online eLearning course emphasises engagement with consumers throughout, and provides practical assistance for clinicians about how this can occur.

Picture 36: Falls prevention and management online eLearning course – engaging the consumer for discharge planning

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/fallsprevention.

11 Preventing and responding to challenging behaviour
SA Health recognises that consumers, carers, workers and volunteers all want
health services to be delivered and received without personal threat or risk.

‘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.

Picture 37: Challenging behaviour spectrum

11.1 Governance and systems for challenging behaviour strategy

Challenging behaviour is a common and serious incident type. The Preventing and responding to challenging behaviour strategy has four streams of work – policy, communications, standards and metrics, and training and education.

SA Health has developed a strategy aimed at reduction of these incidents, and improved recovery should they occur. In 2014-15, the strategy was re-named ‘Preventing and responding to challenging behaviour’ to emphasise proactive actions in preparing for situations of challenging behaviour, and reducing triggers and causes. The term ‘responding to challenging behaviour’ includes a variety of actions such as protecting people from harm, complaints management, communication and debriefing with staff and consumers after incidents.

Each Local Health Network has at least one committee that is responsible for actions to minimise the impact of challenging behaviour. The strategy is being implemented in collaboration with LHNs.
11.1.1 Policy framework

The Preventing and responding to challenging behaviour policy directive, and the policy guideline Preventing and responding to challenging behaviour, violence and aggression were released in May 2015. The latter has replaced the previous Work Health and Safety (WHS) policy.

A toolkit and other resources to support implementation have been developed. Tool 2 is intended to be completed annually in order to develop a risk treatment plan for action.

- Tool 1: Quick Guide to Policy and Legal Information.
- Tool 2: WHS Hazard Identification and Risk Assessment Tool.
- Tool 3: Example Terms of Reference for a Health Service Challenging Behaviour Prevention and Response Committee.
- Tool 4: Clinical Guidelines and additional resources.
- Tool 5: Education and Training Framework.
- Tool 6: Guide to reporting and review of challenging behaviour incidents.
- Tool 7: Evaluation and metrics.

The release was supported by a video that featured executive, senior clinical staff, union and consumer representatives outlining the strategy and recommending it to staff.

Picture 38: Taking Care of Challenging Behaviour with SA Health video screen shot

Policies around minimising the use of restraint and seclusion were also developed in 2014-15, one is specifically for Mental Health services and the other is for all SA Health services. These are designed to align with challenging behaviour strategy.
11.2 Communication strategy

A comprehensive overarching communications plan was developed and implemented to raise awareness for the release of the SA Health Preventing and responding to challenging behaviour strategy, supporting training and education and a toolkit series including resources to support implementation.

Falling out of this overarching communications plan is a further communications plan for each of the five most high risk priority areas as identified by the SA Health Recognition and Management of Challenging Behaviour Advisory Group.

The SA Ambulance Service (SAAS) was identified as the first risk priority area to have its own communications plan developed as over the past three years SA Ambulance has seen a 74% rise in reported challenging behaviour incidents.

SAAS constantly operates in the most extreme and uncertain of situations. They are the ‘front line’ of health care and exist primarily to respond to acute emergency situations. Every call they attend places paramedics and ambulance officers in unknown and potentially dangerous situations.

While other health professionals operate in fixed and familiar environments where they have a complete understanding of their physical surrounds, paramedics and ambulance officers work in completely unfamiliar and often highly volatile environments.

Picture 39: SA Ambulance Service spectrum

Sometimes on the job, Ambos face being spat on, aggressive behaviour sometimes with a weapon, threats of violence, right up to physical assault including kicks, bites and punches.

SAAS have to contend not only with the needs of their patients, but also with members of the public who through anxiety, deliberate belligerence or intoxication, can exhibit the most aggressive and violent forms of challenging behaviour.

A challenging behaviour public awareness campaign was launched utilising advertising and social media to highlight the message that ambulance officers and paramedics can’t save lives when they’re busy fighting for their own.

The social media led campaign included Facebook, Twitter, YouTube, radio ads and venue ads in pubs, clubs and sporting associations (metro and regional).

Within 24 hours of posting the campaign video on Facebook it had reached 2.3 million people, had over 800,000 views and over 70,000 people had liked, shared or made a comment.

The campaign aims to build awareness about the issue, reduce incidents and also increase SAAS staff feeling safer and more supported at work.
Challenging Behaviour ‘Keep your hands off our Ambos!’ campaign web area
www.sahealth.sa.gov.au/LetUsCare

Item 26: Keep your hands off our Ambos venue advertisement
11. Systems of data collection and analysis

To improve data quality and incident management, an integrated reporting system using three modules of Safety Learning System - patient incidents, worker incidents, and a new security incidents module has been built. The security incidents module will replace HealthWatch. Work Health and Safety and Mental Health already use SLS to meet legislative requirements.

The Local Health Network Analytics and Reporting Service (LARS) displays summary data and indicators from each of these modules and further integrated displays are planned. 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 treatment (such as assessment and treatment procedures, and transport for treatment), and also
- the use of restraint and seclusion.

The following flowchart was developed to provide information about reporting requirements.

Item 27: How to report an incident involving challenging behaviour to SLS

Tools 6 and 7 provide information about reporting and data. Tool 6 is a guide to reporting and review of challenging behaviour incidents. Tool 7 outlines data required for evaluation and metrics/indicators.
11.4 **Education, training and competencies**

The Education and Training Framework (Tool 5) outlines the skills and knowledge required for prevention and response to challenging behaviour.

In recognition of the need for an introductory short course for all staff, an online eLearning course was developed through collaboration between Work Health and Safety, Safety and Quality, Mental Health and Digital Media. 1217 staff completed the course after its release in May 2015.

**Picture 40: Introduction to Preventing and Responding to Challenging Behaviour eLearning course - Stages of an incident**

The online eLearning course is intended as an introduction to all staff on the definition of challenging behaviour, and the type of strategies that can be put in place to prevent and, when necessary, respond to these incidents.

The course is structured around the stages of an incident, prevention, early intervention, during and after an incident and emphasises successful communication.

**Picture 41: Consumer and staff perspectives - Introduction to Preventing and Responding to Challenging Behaviour online eLearning course**

*Consumer and staff perspectives*

In a stressful or difficult situation, consumers may not feel that their needs are being met.

They weren’t listening and I was in so much pain. I really lost it …

Staff feel that their safety is compromised and that they are less able to provide good care.

She was really agitated, and I was afraid just going to do her dressings …

... she’d already shouted at me, but I was worried about asking anyone else to help.

Elaine, General Ward Nurse
11.5 Clinical management

Best practice care and symptom management are integral in improving the patient experience and reducing challenging behaviours. The specific skills and knowledge required by a clinician depends on the consumers and their conditions, for whom they provide care.

Tool 4: Clinical Guidelines and additional resources, provides a listing of best practice guidelines for a variety of settings and conditions.

Clinical teams are able to respond to many situations of challenging behaviour. Additional assistance may be required from security officers and/or emergency response teams. The stepped response in the Tool 2: WHS Hazard Identification and Risk Assessment Tool describes these.

11.6 Challenging behaviour incidents

During 2014-15 there were shifts in reporting patterns of challenging behaviour, because of the introduction of the Work Health and Safety incidents module, and amendments to the classifications for challenging behaviour incidents affecting patients. The total number of these incidents decreased in 2013-14 (table 30) because incidents that previously would have been reported as ‘patient behaviour to staff’ were now reported as incidents affecting workers (see also section 11.3). Accuracy and consistency in reporting continue to improve, assisted by Tool 6 -Guide to reporting and review of challenging behaviour incidents.

The total number of Challenging behaviour incidents for 2014-15 was 3903, of which 2195 (56.2%) were recorded from mental health locations.

Table 30: Challenging behaviour level 1 classification 2011-15

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of incidents reported in this category</td>
<td>2738</td>
<td>4257</td>
<td>2909</td>
<td>3903</td>
</tr>
<tr>
<td>Total number of incidents reported</td>
<td>32697</td>
<td>37682</td>
<td>44103</td>
<td>53692</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>
<td>7.3%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System
Under the level 1 classification, 116 incidents were SAC 1 or SAC 2 (3.0%) (table 31). However, high levels of serious harm fall under the category of deliberate or unintentional self harm (20.4% were SAC 1 or 2). A program for suicide prevention is reported in section 1.2.4 mental health area.

Table 31: Challenging behaviour level 2 classification 2014-15

<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>Patient behaviour to other persons</td>
<td>2</td>
<td>9</td>
<td>866</td>
<td>511</td>
<td>30</td>
<td>1418</td>
</tr>
<tr>
<td>Absconded</td>
<td>1</td>
<td>5</td>
<td>499</td>
<td>388</td>
<td>23</td>
<td>916</td>
</tr>
<tr>
<td>Patient behaviour to patient</td>
<td>0</td>
<td>1</td>
<td>333</td>
<td>242</td>
<td>13</td>
<td>589</td>
</tr>
<tr>
<td>Persistent damage to object(s) or disregard for hospital by-laws</td>
<td>0</td>
<td>4</td>
<td>255</td>
<td>199</td>
<td>7</td>
<td>465</td>
</tr>
<tr>
<td>Self harm</td>
<td>72</td>
<td>22</td>
<td>228</td>
<td>126</td>
<td>13</td>
<td>461</td>
</tr>
<tr>
<td>Staff behaviour to patient</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>32</td>
<td>8</td>
<td>54</td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
<td>41</td>
<td>2195</td>
<td>1498</td>
<td>94</td>
<td>3903</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

11.7 Minimising restrictive practices

The challenging behaviour program is aligned with work undertaken by Safety and Quality Unit and the Office for the Chief Psychiatrist on policies for minimising the use of restraint and seclusion. Section 1.2.4.4 of this report includes data on restraint and seclusion use in mental health services.

The new policy directive Minimising Restrictive Practices will introduce similar reporting requirements for all other SA Health services in 2015-16.

In 2014-15 there were 4780 incidents of restraint or seclusion. Of all the restraint and seclusion reported across SA 4506 (94%) is currently reported from mental health services. There was follow-up with family or carers noted for 78% of these incidents (open disclosure). Between 2013-14 and 2014-15, overall harm (SAC 1 and 2) in restraint and seclusion incidents decreased by 68.4%.

11.8 Challenging behaviour incidents affecting workers

During 2014-15 incidents affecting workers were captured in the Safety Learning System. This enabled the reporting of challenging behaviour incidents across SA Health, with the exception of SAAS, where the person affected was a worker (staff member, volunteer, student, or contractor).

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 32: Challenging behaviour level 1 classification 2014-15

<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>1341</td>
<td>973</td>
<td>2314</td>
</tr>
<tr>
<td>Percentage of total incidents reported to the SLS about worker incidents (n = 8245)</td>
<td>16.26%</td>
<td>11.8%</td>
<td>28.07%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System
For incidents where both mechanisms are mentioned, only the primary mechanism is reported. Incidents for the financial year 2014–15, compared with the financial year 2013–14, show a stable trend for ‘Being hit by another person’ (16.8% vs 16.26%), and a decrease in incidents in ‘Mental stress from physical or verbal abuse’ (14.7% in the 2013-2014 vs 11.8% in the current year). Challenging behaviour incidents accounted for 28.1% of all worker incidents reported in the 2014–15, a 3.5% decrease from the 2013–14 financial year (31.6%).

Table 33: Challenging behaviour level 1 classification and risk rating 2014-15

<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>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being hit</td>
<td>1</td>
<td>50</td>
<td>486</td>
<td>641</td>
<td>163</td>
<td>1341</td>
</tr>
<tr>
<td>Mental stress</td>
<td>1</td>
<td>17</td>
<td>276</td>
<td>507</td>
<td>172</td>
<td>973</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>67</td>
<td>762</td>
<td>1148</td>
<td>335</td>
<td>2314</td>
</tr>
<tr>
<td>Total %</td>
<td>0.09%</td>
<td>2.9%</td>
<td>32.93%</td>
<td>49.61</td>
<td>14.48%</td>
<td>4628</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

The majority of challenging behaviour claims were risk rated as being of moderate to low risk in nature (82.54%).

A total of 78 workers compensation claims were made by workers for injury arising from challenging behaviour in the 2014-15, being 5.5% of all worker compensation claims made in this period.

Mechanisms of injury were being assaulted (54 claims) and exposure to workplace violence (24 claims).

Table 34: Challenging behaviour level 2 classification and risk rating 2014-15

<table>
<thead>
<tr>
<th>Challenging behaviour level 2 classification</th>
<th>Extreme</th>
<th>High</th>
<th>Moderate</th>
<th>Low</th>
<th>No value</th>
<th>Total</th>
<th>No of workers compensation claims made</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being assaulted by person</td>
<td>1</td>
<td>49</td>
<td>446</td>
<td>564</td>
<td>150</td>
<td>1210</td>
<td>54</td>
</tr>
<tr>
<td>Hit by person accidentally</td>
<td>0</td>
<td>1</td>
<td>36</td>
<td>69</td>
<td>12</td>
<td>118</td>
<td>-</td>
</tr>
<tr>
<td>Exposure to violent event (mental stress)</td>
<td>1</td>
<td>16</td>
<td>263</td>
<td>470</td>
<td>157</td>
<td>907</td>
<td>24</td>
</tr>
<tr>
<td>Racial or sexual behaviour</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>30</td>
<td>6</td>
<td>45</td>
<td>-</td>
</tr>
<tr>
<td>Not classified</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>11</td>
<td>3</td>
<td>19</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>67</td>
<td>758</td>
<td>1144</td>
<td>328</td>
<td>2299</td>
<td>78</td>
</tr>
</tbody>
</table>

Source: Safety Learning System
11.9 Challenging behaviour incidents where security services provide assistance

Security Services operate at many health services and have a variety of roles.

Security officers in metropolitan health services responded to 8126 Code Black situations in 2014-15. Of these 4275 calls (53%) were made by staff in emergency departments.

Table 35: Challenging behaviour incidents with Code Black call in SA Health metropolitan hospitals

<table>
<thead>
<tr>
<th>Code Black calls</th>
<th>2013-14</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number</td>
<td>%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>4292</td>
<td>55</td>
</tr>
<tr>
<td>Emergency Departments</td>
<td>3465</td>
<td>45</td>
</tr>
<tr>
<td>Total</td>
<td>7757</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

*Hospitals included are from CALHN, SALHN, NALHN and WCHN.

There is some variation between health services around what constitutes a Code Black call. The following is from the Preventing and responding to challenging behaviour policy directive.

> 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 threatening behaviours can be exhibited by a patient or by other person(s).

> It is a request for urgent/emergency assistance.

> The Code Black signal can be triggered through a duress alarm, emergency phone number, or other local mechanism. The equivalent code for SA Ambulance Service is Code 51.

> Code Black is defined by Standards Australia as being used ‘For personal threat (armed or unarmed persons threatening injury to others or themselves, or illegal occupancy)’ AS 3745-2010.

Most metropolitan services have a team (Emergency Response team) comprising clinical and security staff, that attends in response to a Code Black call. This team works with the home team, and assist by de-escalating the situation, providing expert care and restoring a safe environment. Many of these incidents only require the Emergency Response team or the security officers to attend and provide advice or support. In some incidents there is a range of actions taken such as restraint of the patient, or escorting an aggressive non-patient from the facility.

In addition, as planned preventative/precautionary measures, security officers also provide assistance to staff who are providing care or treatment in a situation where challenging behaviour is predicted.

A module of Safety Learning System for recording incidents when security staff attend is near completion.

Further information about the background and work of this program is available on the SA Health website Preventing and responding to challenging behaviour at www.sahealth.sa.gov.au/challengingbehaviourstrategy.
Further information regarding this report or the Safety and Quality Unit is available on the SA Health website 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.
In 2014-15 the following clinical guidelines were released including:

**New clinical guidelines:**

**SA Child Health Clinical Network – Paediatric Clinical Practice Guidelines**
- Staphylococcus aureus bacteraemia (SAB) management guideline (adult)

- Desmopressin
- Indomethacin
- Probiotic (infloran)
- Pyridoxine

**SA Perinatal Practice Guidelines**
- GP Obstetric Share Care Program Protocols
- Vaccines recommended in pregnancy

**Infection Control Service**
- Aseptic Technique
- Antimicrobial Stewardship Policy Directive and Prescribing Guidelines
- Intravenous to Oral Switch Guideline for Adult Patients-Can antibiotics S T O P

**Revised clinical guidelines:**

**SA Perinatal Practice Guidelines**
- Cardiac disease in pregnancy
- Cardiotocography
- Concealed or denied pregnancy
- Cystic fibrosis in pregnancy
- Cytomegalovirus
- Dermatophyosis dermatomy tinea (ring worm)
- Diabetes mellitus and gestational diabetes
- Enteroviruses (coxsackie)
- Epilepsy
- Epstein-barr virus
- Hepatitis B
- HIV in pregnancy
- Induction to labour technique
- Infection prevention and control in perinatal
- Intent to harm fetus
- Intravenous phentoin
- Listeria in pregnancy
- Malaria in pregnancy
- Maternal anaphylaxis
- Measles and measles contact
- Ocytocin high dose regimen IUFD
- Oxytocin augmentation and IOL
- Parvovirus
- Pediculosis head lice
- Perinatal loss
- Peripartum prophylactic antibiotics
- Pruritic Urticarial Papules and Plaques of Pregnancy (PUPPP)
> Reduced fetal movement
> SA Notifiable Diseases
> Scabies (Sarcopes scabiei)
> Seizures in pregnancy
> Sepsis in pregnancy
> Syphilis in pregnancy
> Twin Pregnancy
> Use of psychotropic medicine
> Vitamin D Deficiency
> Vitamin and mineral supplementation in pregnancy
> Women with high body mass index (BMI)

**Infection Control Service**

> Patients with Vancomycin-resistant enterococci (VRE)
> Antimicrobial Stewardship Policy Directive and Prescribing Guidelines
> SA HIV Post Exposure Prophylaxis (PEP) Management Plan

**South Australian Medicines Advisory Committee (SAMAC)**

> Surgical Antibiotic Prophylaxis Guidelines

**Medicines and Technology Policy and Programs**

> Opioid Prescribing on Discharge

**SA Neonatal Clinical Network - SA Neonatal Medication Guidelines**

> Amoxycillin
> Amphotericin (liposomal)
> Calcium Gluconate
> Captopril
> Ceftazidine
> Chlortal hydrate
> Dexamethasone
> Diazepam
> Diazoxide
> Fentanyl
> Flucloxacinil
> Hydralazine
> Ibuprofen
> Lamivudine
> Magnesium Sulfate
> Morphine
> Nevirapine
> Noradrenaline
> Phenobarbitone
> Potassium
> Ranitidine
> Sildenafil
> Sodium chloride
> Zidovudine