South Australian

Patient Safety Report

2017

Government of South Australia

SA Health

Acknowledgements

The Safety and Quality Unit in the Department for Health and Wellbeing 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.

ISBN: 978-1-76083-003-8

Contents

Executive Summary

The new look Patient Safety Report demonstrates the continued systematic improvement across SA Health in a number of safety and quality programs, during July 2016-June 2017.

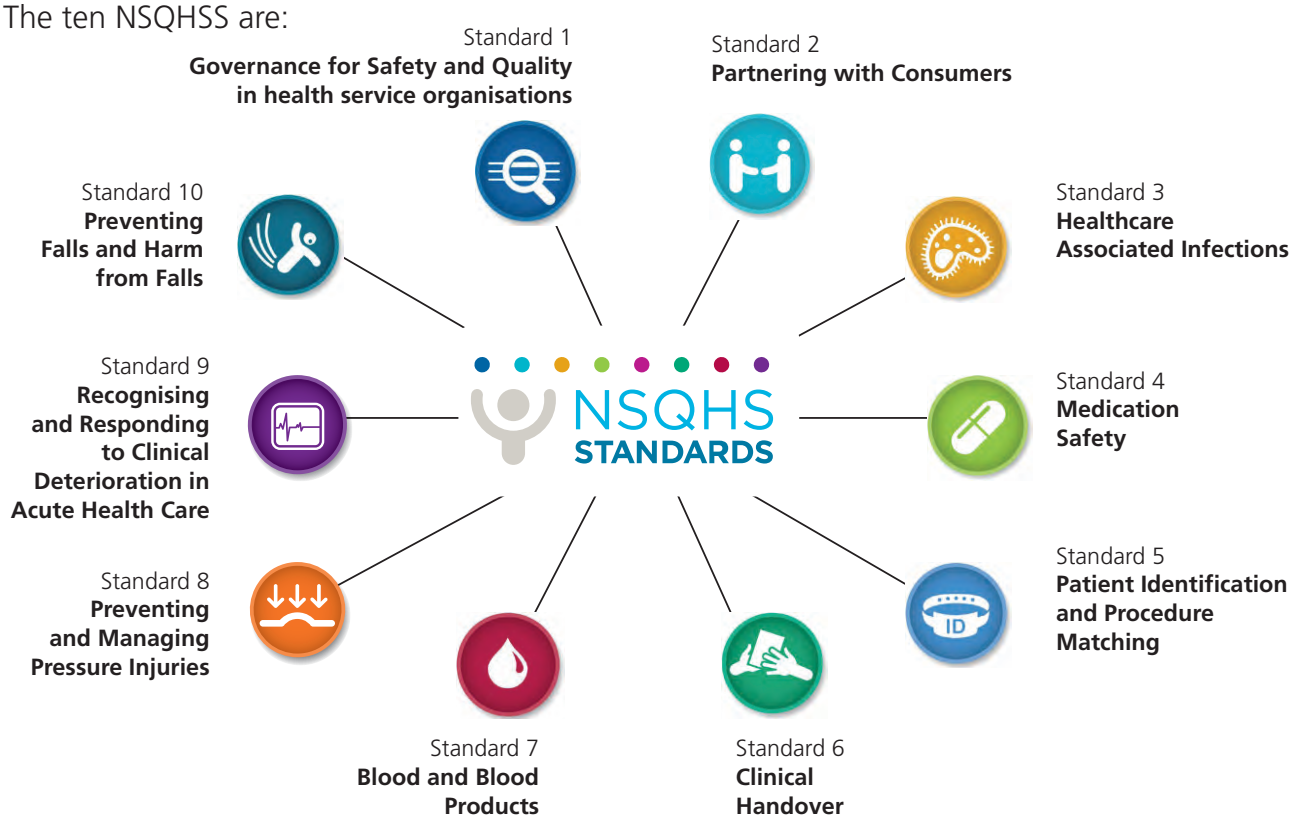
SA Health is committed to creating and maintaining a sustainable quality environment which provides services that are consumer centred, driven by information and organised by safety[1], by ensuring that:

> 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.

Our health services meet national standards

Accreditation is one of the most important drivers for safety and quality improvement in SA Health. 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).

The ten NSQHSS are:



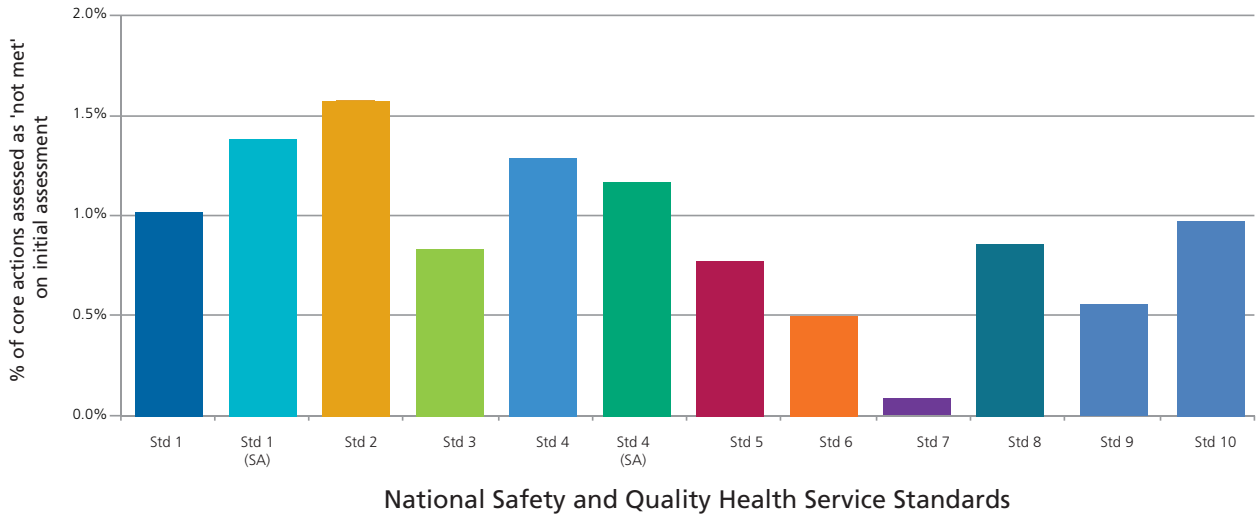
1 Australian Commission on Safety and Quality for Health Care, Australian Safety and Quality Framework 2010.

Between 2016 and 2017, 28 public health services undertook organisational wide assessment with a further 51 undertaking mid-cycle assessment.

SA Health performed well in comparison to the national average on most actions, with all services meeting Standards 2, 5, 6, 7, 8, 9 and 10 on initial assessment.

SA also performed better than the national average for Standard 4 – Medication Safety.

Graph 1: National and state 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

SA Ambulance Service (SAAS) accreditation

In a milestone for ambulance services in Australia, SA Ambulance Service has led the way in the journey towards accreditation against the National Safety and Quality Health Service Standards, being the first jurisdictional ambulance service to go through the full accreditation process. A number of different areas in the organisation were visited by surveyors, including head office at Eastwood, Fulham complex, MedSTAR base, six metropolitan stations and 11 country stations (six career and five volunteer). The final outcome is unknown at this point of time; however initial feedback has been positive.

Safety and Quality Programs

Safety and Quality 2017-19 Work Plan

The SA Health Safety and Quality 2017-19 Work Plan has been developed to identify priorities for SA Health to improve the safety and quality provided to consumers across SA Health services.

Safety and Quality priority areas include:

> Priority Area 1 Patient safety
> Priority Area 2 Partnering with patients, consumers and community
> Priority Area 3 Quality cost and value
> Priority Area 4 Supporting health professionals to provide safe and high quality care
> Priority Area 5 Safety Learning System (SLS)
> Priority Area 6 Communication strategy to support safety and quality

Further information is available on the SA Health Safety and Quality area at www.sahealth.sa.gov.au/safetyandquality.

Online learning is a key training tool for safety and quality

50,964 online eLearning courses on various safety and quality topics were completed in 2016-17.

Resuscitation Planning – 7 Step Pathway

The new Resuscitation Planning – 7 Step Pathway Policy Directive was released in July 2016.

Quality of life can be improved by partnering early with a patient, their Substitute Decision Maker, Person Responsible or significant others in making and documenting decisions about end-of-life treatment and care.

The Resuscitation Plan – 7 Step Pathway Policy Directive is a step-by-step process to assist clinicians and consumers to make decisions about resuscitation and other life-

sustaining treatment, and to develop and document an end-of-life clinical care plan for a patient. The plan describes what types of care people want and do not want. The 7 Step Pathway takes into account people's Advance Care Directives (ACD) and other advance care plans.

The policy is supported by an extensive toolkit including fact sheets, resources and an online eLearning course for clinical staff to support implementation.

The tools and fact sheets include information about recognising when a person is nearing the end of their life, and how to go through the 7 Step Pathway. There are forms to document the plans and information for consumers. These are in use and Local Health Networks are implementing the processes.

Recognising and Responding to the Deteriorating patient

Effective and early recognition and response to clinical deterioration is an essential component of the delivery of safe, high quality health care.

One way that clinical staff closely monitor the condition of their patients is through use of the RDR charts (Rapid Detection and Response to Clinical Deterioration). These charts allow tracking of a series of physiological measures such as blood pressure, temperature, and to make it clear across a shift or a day if a patient is not doing as well as expected, or there is rapid deterioration, and there is a need for an emergency response.

Highlights:

- Review of RDR charts underway.
- Development and approval of a strategy to support consumer initiated escalation of care and support clinical communication.

There are systems for clinical staff to escalate care, including calling for an Emergency Response team, when they observe deterioration and need additional support to manage the patient's condition.

There is a series of these charts to cater for babies and children of different ages, as well as charts for adults and pregnant and post-partum women. A review of these charts commenced this year and is expected to continue into 2018. The Enterprise Patient Administration System (EPAS) system has been set up to enable similar tracking, and escalation of care.

Picture 1: Family discussions with staff following early recognition of deteriorating patient

Consumer Initiated Escalation of Care

Patients and their family and carers are often familiar with what is 'normal' for the patient even when acutely unwell. Sometimes unexpected and/or rapid changes occur, and there are times when changes are not recognised by staff, but can be seen by family members or carers who know the patient well.

Patients, their families and carers have the right to expect that:

> there is good communication that encourages them to raise questions and concerns at any time, and receive a timely response from clinical staff

> a system exists that enables them to escalate care if:
  - the deterioration appears to be sudden, severe and unobserved by staff
  - a response by staff to their concerns about changes in the patient's condition is delayed, absent or perceived to be insufficient.

An executive committee which included consumers and an academic researcher has considered evidence of best practice in this emerging area of health care. The committee developed a strategy for approval by the SA Health Safety and Quality Strategic Governance Committee.

In 2017-18, a Consumer Initiated Escalation of Care Local Health Network (LHN) Advisory Group will be formed to provide advice on current escalation and discharge processes, and support local transition to the statewide model.

Initiatives under the strategy include:

> establishing a recognisable community message for how consumers can escalate care if they experience or observe deterioration and are worried

> building on current programs in each LHN

> promoting improved clinical communication

> supporting consumer initiated escalation of care
  - within a public hospital visit or stay, and
  - upon and during the hours after discharge.

> assisting health services to meet the requirements of the National Safety and Quality Health Service Standards 2nd edition.

End of Life Care Strategy

Care of people during their last year of life may be delivered by a variety of health providers and there is a challenge in ensuring coordination and best practice to meet the needs of people, their families and carers during this significant time.

In December 2016, the Transforming Health Ministerial Clinical Advisory Group endorsed the development and implementation of an End of Life Care Strategy for South Australia (the Strategy), with the aim to ensure all South Australians' experience high quality end of life care.

Highlights:

- Establishment of an End of Life Care Strategy Program Board to oversee an extensive program of work to improve care provided to people during the last year of their life.

The newly established SA Health End of Life Care Strategy Program Board will be supported by the Department for Health and Ageing Safety and Quality Unit to develop a strategic plan which will detail the goals, key deliverables for the next two years.

Consumer and stakeholder engagement will underpin stronger partnerships across the health care system and the community. In turn this will assist in building innovative, coordinated and comprehensive end of life care that best matches the needs and preferences of South Australians.

Clinical Handover and Patient Identification

SA Health seeks to improve patient safety by reducing risks that arise from inaccuracies, errors, delays, omissions or failures in the systems of exchange and documentation of clinical information, including verification of the patients identity and matching them with their intended care.

Highlights:

- Revision and combining a number of related policies and guidelines.

Information exchange in health care increasingly relies on electronic systems such as MyHealth Record, Enterprise Patient Administration System (EPAS), electronic systems for discharge summaries, and policies need to guide the confidentiality, safety and quality of these systems, and thus patient care.

As part of their scheduled review, a decision was made to combine the policies and guidelines for Clinical Handover and Patient Identification, along with Surgical Team Safety Checklist.

This combination is aligned to the National Safety and Quality Health Service Standards (2nd Edition) that will include a new standard called Communicating for Safety. This alignment will support health services to meet the accreditation requirements. A draft policy directive was distributed for consultation and feedback.

Pressure injuries

Highlights:

- Pressure injury screening enhanced in EPAS.

Most pressure injuries are preventable, yet when they occur they result in pain, disfigurement, reduced quality of life and prolonged rehabilitation for affected individuals and their families. Systematic risk identification and evidence-based management is required in order to reduce the incidence and prevalence of pressure injuries, and to prevent or delay complications arising from them.

To support early identification of risk, the EPAS team built enhanced screening tools that matched the existing paper-based forms (MR95 and 95A) that underpin care planning.

SA Health Procurement led a team of expert clinicians to develop a statewide list of wound care products.

Awareness of the need to report pressure injuries into the Safety Learning System (SLS) Incident Management module is increasing. Information accuracy and open disclosure rates are good.

A review of the Pressure Injury policy directive is planned for 2017-18.

Minimising Restrictive Practices – restraint and seclusion

Restrictive practices are potentially harmful non-therapeutic interventions, and their use can be avoided by positive changes to the provision of assessment, treatment, care and support.

The use of restrictive practices must therefore be a last resort, and only used after alternative strategies have failed or there is imminent or actual health or safety risk. In these situations workers with expertise will apply, monitor, and support recovery afterwards, in order to reduce harm.

The SA Health Minimising Restrictive Practices Policy Directive, and a Restraint and Seclusion in Mental Health Services Guideline were released late in 2015. Associated with these are tools and resources for clinical staff. Implementation is proceeding in all LHNs.

All use of restraint is required to be reported into the SLS. Some are reported by security staff after attending a Code Black call, and some by clinical staff. Planning commenced for a point prevalence audit to evaluate implementation and establish baseline data.

Preventing falls and harm from falls

SOUTH AUSTRALIA FALLS PREVENTION

People come to health services for care of injuries from **FALLS**

LAST YEAR IN SOUTH AUSTRALIA

21,120 people were admitted to public hospitals injured AFTER A FALL.

OVER **65%** of these were people OVER 65.

395 older people DIED IN HOSPITAL as a result of injuries from a fall.

That figure is over **10x** HIGHER than the 1,927 admitted to hospital for MOTOR VEHICLE INJURIES.

6.9 DAYS is AVERAGE LENGTH OF STAY in hospital for injured older people

During health care, **FALLS** are the MOST NUMEROUS REPORTED incident

10,691 REPORTED FALLS INCIDENTS in 2016.

In SA there has been a STEADY DECLINE in serious falls (SAC1 and 2).

Potentially there have been **358 serious falls AVOIDED.**

EFFECTIVE STRATEGIES

- Quick POST FALL TEAM REVIEWS to reduce repeat falls.
- HOURLY ROUNDING especially for patients who have dementia or delirium.
- **100%** of services that have been accredited PASSED Standard 10. Committees and staff should be proud of this achievement.
- **14,325+** STAFF have completed the online eLearning course on Falls Prevention since its launch in April 2014.

Health Professional www.sahealth.sa.gov.au/FallsPrevention
General www.sahealth.sa.gov.au/Falls

Government of South Australia
SA Health

16026.1 (ALL SA) March 2017 * All data relates to all of South Australia.

Patient Incident Management and Open Disclosure

The SA Health Patient Incident Management and Open Disclosure Policy Directive and Toolkit were released in September 2016.

A patient incident is any event or circumstance which could have (near miss) or did lead to unintended and/or unnecessary psychological or physical harm to a patient, that occurs during an episode of health care.

Open disclosure is the process of providing an open, consistent approach to communicating with patients/ consumers, their family, carer and/or support person following a patient incident. This process includes expressing regret.

All SA Health staff are required to participate by reporting all incidents in the Safety Learning System Incident Management Module and ensuring that open disclosure occurs when required.

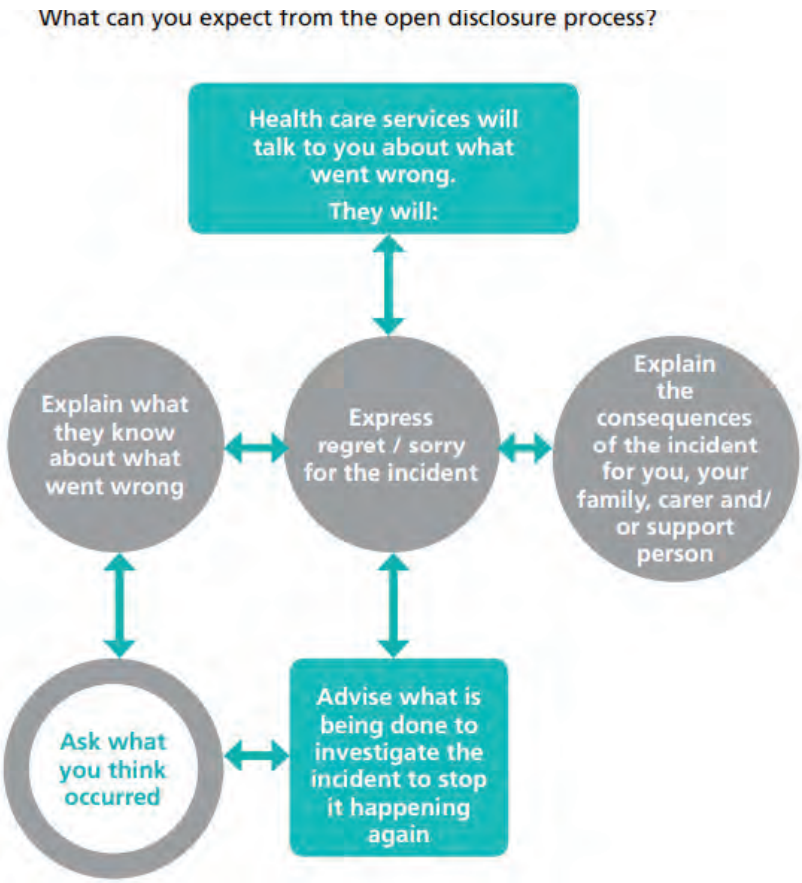
Highlights:

- Release of the SA Health Patient Incident Management and Open Disclosure Policy Directive and Toolkit.
- Staff and consumer information and resources are available.
- Release of the Lookback Review Policy Directive, and revision of the RCA (Root Cause Analysis) Policy Directive.

A comprehensive toolkit, including fact sheets and resources to support staff and consumers in the patient incident management and open disclosure process are available at www.sahealth.sa.gov.au

Consumer information and resources on open disclosure are available in the Health topics section of the SA Health website at www.sahealth.sa.gov.au

Picture 2: Consumer information on what to expect from the open disclosure process



Incidents and harm

Patient incidents are recognised, reported and analysed to improve safety systems and prevent recurrence.

SA Health is committed to improving the safety and quality of patient care and achieving the best patient outcomes possible. The Safety Learning System (SLS) Incident Management module supports SA Health staff to record, manage, investigate and analyse patient and worker incidents, as well as consumer feedback.

Between 1 July 2016 and 30 June 2017, 60,510 incidents were reported into the SLS, a 9.4% increase from 2015-16 (55,318), and a 12.4% increase from 2014-15.

Increasing numbers of incidents reported with an accompanying decrease in harm can be interpreted as strong reporting culture with the successful implementation of strategies.

Safety Learning System Highlights:

- Published new SLS topic guides about how to report:
  - patient falls and other injuries
  - skin tears
  - medical devices or equipment failures
  - open disclosure
  - FAQ – reporting patient incidents
- analysing contributing factors.
- information sharing guidelines.
- Review of the data fields and design of the patient incident module (notifier and managers page) and also the worker incident module.

The three most common types of incidents (by level 1 Incident Classification) has been consistent over the last three year period.

1. MEDICATION

2. PATIENT FALLS AND OTHER INJURIES

3. CHALLENGING BEHAVIOUR

Table 1: Number of incidents reported by Level 1 classification 2014-17

Primary classification (Level 1)	2014-15	2015-16	2016-17
Medication	12097	12056	12628
Patient falls and other injuries	12266	12767	12604
Challenging behaviour	3912	4714	5620
Restraint/seclusion	4790	3847	4922
Implementation of care	3854	3513	3481
*Pressure injury/ulcer/sore	2378	3035	3307
Treatment, procedure	2536	2761	3267
Assessment, appointment, admission, transfer, discharge	2967	2952	3137
Communication and teamwork	2214	2647	2997
Patient information	1793	2040	2474
Clinical assessment	2229	2145	2403
Medical device/equipment	1416	1297	1605
Staffing, facilities, environment	1180	1143	1525
Neonate	27	152	282
Maternal	117	138	156
Total	**53776**	**55207**	**60408**

Source: Safety Learning System

*this total number includes pressure injuries that were present on admission (797 in 2014-15; 1237 in 2015-16; and 1413 in 2016-17).

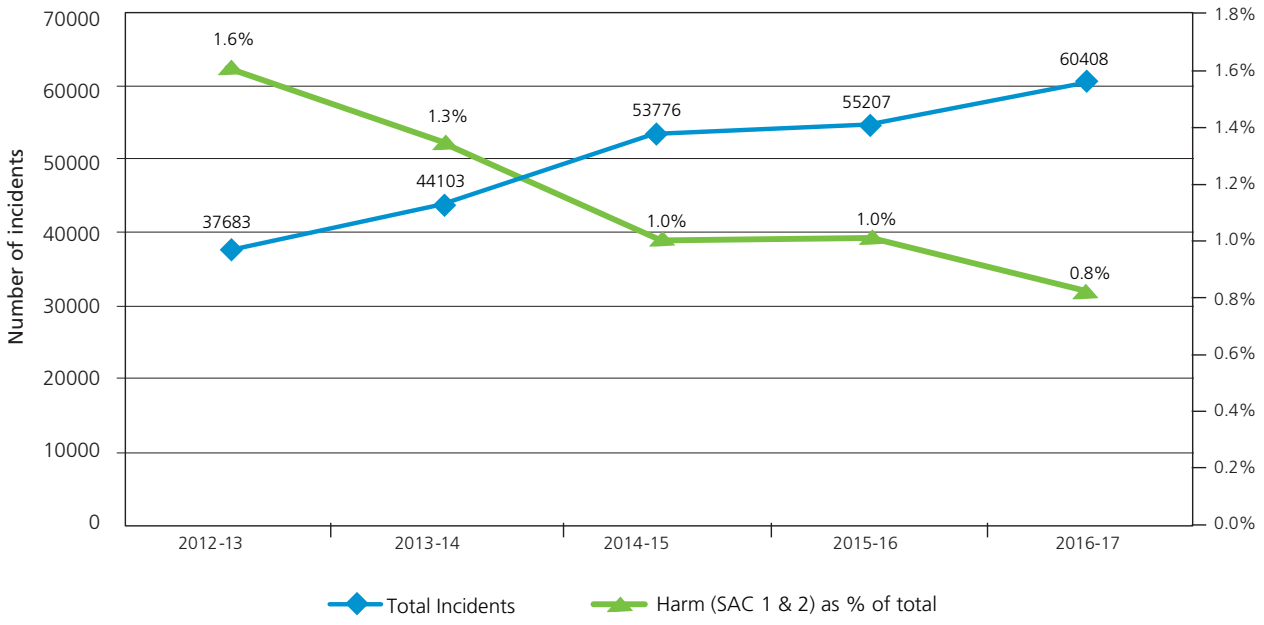
A reduction in overall harm

The Safety Assessment Code (SAC) rating is derived from a matrix that matches consequence of the incident for the patient with the likelihood or probability of recurrence. The SAC rating guides the level of investigation and management for each incident that is undertaken by the patient incident managers.

SAC 1 and 2 are considered to represent harmful incidents.

Despite the **increase in incidents**, the proportion and number of incidents (SAC 1 and 2) resulting in **harm is reducing**. The overall proportion of these harmful incidents has decreased since 2012 from 1.6% to 0.8% in 2016-17. Between 2010-11 and 2016-17, there was a reduction in the total number of harmful incidents (SAC 1 and 2) from 818 to 500.

Graph 2: Total of incidents in proportion to SAC 1 and 2



Source: Safety Learning System

SAC 3 and 4 incidents indicate emerging trends, issues and opportunities for improvement. This enables a focus on improvement and preventing similar incidents occurring again. The proportion of near-miss incidents reported has decreased during the last three years (14.6% in 2014-15, 14.1% in 2015-16, and 13.9% in 2016-17).

We're continuing to see a steady improvement in patient safety

Between 2014-15 and 2016-17, the biggest reduction in numbers of SAC1 and 2 incidents were for those classified as:

> Treatment, procedure (45 to 32)
> Clinical assessment (43 to 31)
> Medication (22 to 13)
> Access, appointment, admission, transfer, discharge (22 to 13)
> Communication and teamwork (13 to 6)
> Pressure injury (8 to 3)

The largest reduction in the proportion of harmful incidents was for maternal and neonatal incidents, and incidents involving challenging behaviour.

Table 2: Harmful incidents (SAC 1 and 2) by Level 1 classification

Harmful incidents (SAC1 and 2) by Level 1 classification	2014-15		2015-16		2016-17	
	Number of SAC1 and 2 / total number	SAC1 and 2 as % of total	Number of SAC1 and 2 / total number	SAC1 and 2 as % of total	Number of SAC1 and 2 / total number	SAC1 and 2 as % of total
*Maternal	62 / 117	53.0%	34 / 138	24.6%	14 / 156	9.0%
*Neonate	4 / 27	14.8%	11 / 152	7.2%	9 / 282	3.2%
Challenging behaviour	118 / 3912	3.0%	123 / 4714	2.6%	132 / 5620	2.3%
Implementation of care	31 / 3854	0.8%	44 / 3513	1.3%	49 / 3481	1.4%
Patient falls and other injuries	154 / 12266	1.3%	156 / 12767	1.2%	169 / 12604	1.3%
Clinical assessment	43 / 2229	1.9%	44 / 2145	2.1%	31 / 2403	1.3%
Treatment, procedure	45 / 2536	1.8%	68 / 2761	2.5%	32 / 3267	1.0%
Medical device/ equipment	11 / 1416	0.8%	10 / 1297	0.8%	11 / 1605	0.7%
Staffing, facilities, environment	7 / 1180	0.6%	8 / 1143	0.7%	7 / 1525	0.5%
Access, appointment, admission, transfer, discharge	22 / 2967	0.7%	25 / 2952	0.8%	13 / 3137	0.4%
Patient information	5 / 1793	0.3%	4 / 2040	0.2%	6 / 2474	0.2%
Communication and teamwork	13 / 2214	0.6%	10 / 2647	0.4%	6 / 2997	0.2%
Restraint / seclusion	6 / 4790	0.1%	0 / 3847	0.0%	5 / 4922	0.1%
**Pressure injury / ulcer / sore	8 / 2378	0.3%	8 / 3035	0.3%	3 / 3307	0.1%
Medication	22 / 12097	0.2%	22 / 12056	0.2%	13 / 12628	0.1%
Total	**551 / 53776**	**1.0%**	**567 / 55207**	**1.0%**	**500 / 60408**	**0.8%**

Source: Safety Learning System

*in 2014-15 there were changes to the SLS classifications for these incidents, but incidents with harm have occured over a number of years.

**numbers include pressure injuries that were present on admission (see table 1).

Open disclosure

In 2016-17, open disclosure was reported as having occurred for 58.2% of all incidents reported, and during 2015-16 for 58.6% of incidents.

Highlights:

- Open disclosure toolkit developed comprising 18 tools for staff and information for consumers, family and carers.
- Internet webpages for staff and consumers.
- Level 1 Open Disclosure training provided by Cognitive Institute to 20 groups of senior managers.

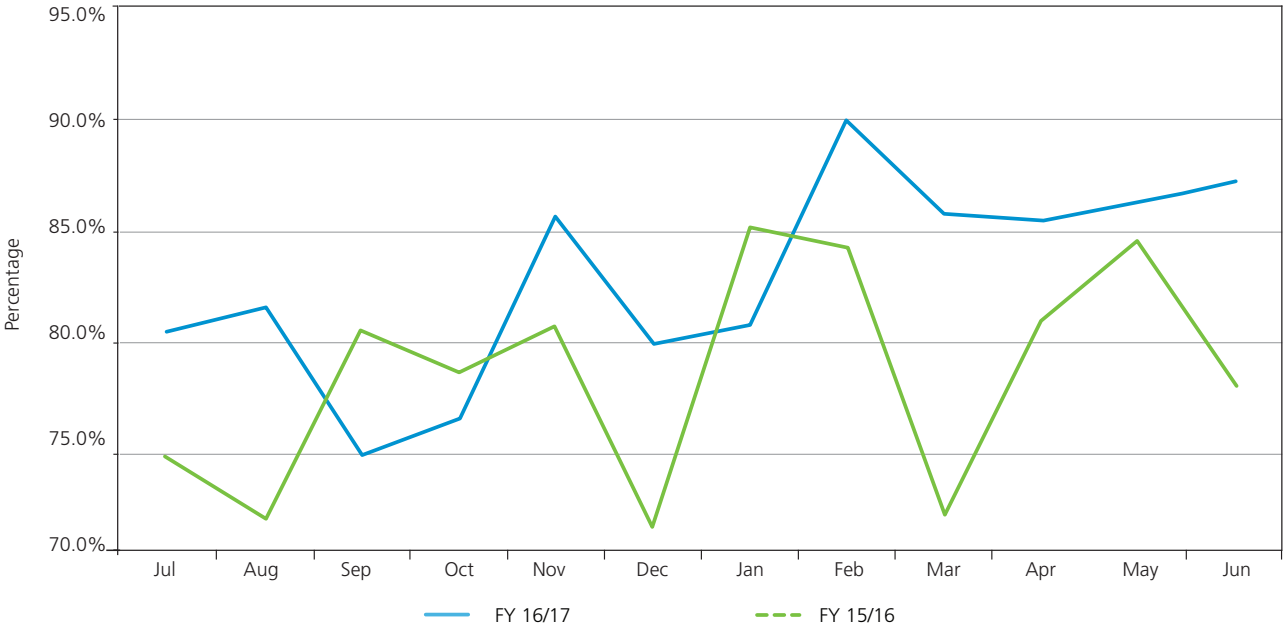
Table 3: Percentage of open disclosure made by primary incident classification (Level 1) 2015-17

Primary incident classification	% of incidents disclosed	
	2015-16	2016-17
Patient falls and other injuries	78.5	80.9
Medication	43.5	44.4
Challenging behaviour	64.7	65.7
Implementation of care	50.8	54.7
Treatment, procedure	49.2	46.1
Assessment, appointment, admission, transfer, discharge	48.3	50.7
Clinical assessment	40.9	42.0
Patient information	37.4	33.7
Communication and teamwork	41.6	43.2
Medical device/equipment	40.5	43.7
Staffing, facilities, environment	41.1	43.4
Pressure injury/ulcer/sore	78.5	80.0
Restraint/seclusion	82.3	66.5
Maternal	94.9	83.3
Neonate	72.4	69.5
Overall	**58.6%**	**58.2%**

Source: Safety Learning System

The rate of open disclosure varies with the primary incident classification type (table 3). The incident types most frequently disclosed to consumers are maternal, neonatal, falls and other injuries, and pressure injuries.

Graph 3: Proportion of SAC 1 and 2 patient incidents openly disclosed to patient / family at the time



Source: Safety Learning System and LARS

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

Major State Reviews

Review of serious failures in reported test results for prostate specific antigen (PSA) testing of patients by SA Pathology

Between November 2015 and March 2016 some post-prostate cancer patients who had undergone prostate cancer monitoring tests at SA Pathology received higher than expected test results.

In April 2016, the Chief Executive, SA Health asked the Australian Commission on Safety and Quality in Health Care to conduct an independent review of these incidents. The review also examined the circumstances which led to 68 patients who had prostate cancer screening tests to receive test results which were accurate, but accompanied by an incorrect comment.

The report was released on 1 August 2016 and in summary the review panel:

> found SA Pathology failed to act on technical warnings from the laboratory system that the tests were inaccurate. No action was taken until a complaint from a urologist in late January 2016.

> found when the issue received public attention, appropriate action was, and has since been taken.

> found management, governance and accountability of SA Pathology was seriously deficient and SA Pathology should be restructured to bring it in line with management practices in place at comparable Australian providers.

> made five recommendations, which can be read in full in the report, including that SA Pathology: issue a public apology, implements an organisation structure that ensures quality control procedures are operational, meets national laboratory standards, and log all incidents in the statewide Safety Learning System (SLS) Incident Management module.

Key actions taken in response to the recommendations include:

> SA Pathology has taken steps to improve its governance by introducing a new management team, and will also be undertaking a review of all quality control processes.

> SA Pathology has engaged in a review of incident reporting procedures and a process of staff education about incident reporting and open disclosure.

> A team from NSW Pathology will review the organisation.

> SA Pathology has requested an early NATA (National Association of Testing Authorities) review of procedures in its automated laboratory.

Review of the incident notification, management and analysis of incorrect dosing of Cytarabine of Acute Myeloid Leukaemia at Flinders Medical Centre and Royal Adelaide Hospital

Between the end of July 2014 and the end of January 2015, five patients at the Royal Adelaide Hospital (RAH) and five patients at the Flinders Medical Centre (FMC) received a daily dose of Cytarabine instead of a dose twice a day, during the consolidation phase of treatment for Acute Myeloid Leukaemia (AML). This was the result of the RAH AML protocol containing the incorrect dose.

An independent review, led by Professor Villis Marshall Chair of the Board of the Australian Commission on Safety and Quality in Health Care (ACSQHC), was conducted into the incorrect dosing of cytarabine. The outcome of that review was outlined in the 2015-16 Patient Safety Report.

As a result of the findings of the independent review, the Chief Executive, Department for Health and Ageing (SA Health) commissioned another independent review to assess whether the action by the health services concerned after the error was discovered complied with SA Health policies requiring investigation and report on the cause of the error; implementation of any recommendations to prevent it reoccurring and "open disclosure" to the ten affected patients and their families.

The second independent review was conducted by the ACSQHC. The findings were released in September 2016 and the panel:

> found there was a serious failure of clinical governance at the RAH and responsible staff had little or no knowledge of the Incident Management guidelines and did not make an incident report in the SLS within the required time frame.

> found the health services did not provide sufficient education on system response or policies and open disclosure was not well thought out or properly planned, nor was the provision of additional support to the patients.

> found the issue of compensation was poorly managed and led some patients to believe SA Health was being defensive and covering up.

> made six recommendations, which can be read in full in the report, including that:
  - Central Adelaide Local Health Network (CALHN) review its clinical governance framework, structure.
  - clinical and management staff who failed to comply with SA Health incident management and open disclosure policies undertake training as a matter of urgency.
  - SA Health draft Patient Incident Management and Open Disclosure Policy Directive, its tools and associated documents be finalised and implemented, as a matter of urgency, and accompanied by a systematic and audited training program.
  - SA Health develop an understanding and appropriate protocols with SAicorp, which is the captive insurer for the Government of South Australia.
  - legislative provisions which operate to protect certain information in the Safety Learning System from disclosure should be reviewed.

Key actions taken in response to the recommendations include:

> an independent review of safety and quality systems, leadership and functions in CALHN was completed in December 2016. All eight recommendations were accepted and an implementation plan is being developed. This is a longer-term project which is anticipated to take between three to five years to implement.

> in July 2016, a new Lookback Policy Directive, a revised Root Cause Analysis Policy and a revised SA Health Patient Incident Management and Open Disclosure Policy with associated documents and tools, were released.

> targeted patient incident management and open disclosure training programs were completed. Ongoing training programs are underway for other staff across SA Health.

> a protocol between SA Health and SAicorp, known as the SA Health Guide, was endorsed in December, 2016.

> on 15 September 2016, a notice was published in the SA Government Gazette removing the legislative protections on information in the Patient Incident Review and Analysis Phase of the SA Health SLS Incident Management Module.

Oakden Review

In response to concerns raised around the quality and provision of clinical care to residents by the Oakden Older Persons Mental Health Service, the Chief Psychiatrist, an independent statutory officer under section 90 of the Mental Health Act 2009, undertook an independent review.

The Oakden Report and SA Health's Response to the Review were released on 20 April 2017. The report made six recommendations, which can be read in full in either the Report or the Response document, covering the following:

> development of a specialised contemporary model of care for people over 65 years of age who live with the most severe forms of disabling mental illness and/or extreme behavioural and psychological manifestations of Dementia

> the provision of appropriate infrastructure to implement the model of care

> development of a staffing model that utilises the full range of members of a multidisciplinary service

> development of a new and appropriate clinical governance system

> ensuring there are people in senior leadership positions that can create a culture that values dignity, respect, care and kindness for both consumers and staff

> development of an action plan based on Trauma Informed Principles and the six core strategies developed by the National Centre for Trauma Informed Care (NCTIC).

Key actions taken in response to the recommendations include:

> in June 2017 the SA Health Oakden Response Plan Oversight Committee was established to provide oversight and guidance to SA Health in implementing the six recommendations outlined in the Oakden Report.

> communiques will be used to share information covered in the SA Health Oakden Response Plan Oversight Committee meetings with key stakeholders. A expert working group will be established to implement each of the recommendations.

> the Statewide Specialised Contemporary Model of Care Expert Working Group is scheduled to hold its first meeting on 7 July 2017.

> on 14 June 2017, 14 Makk and McLeay residents were transitioned to Northgate House, which comprises two eight-bed 'houses' – Woodland and Beachside. Residents have settled into their new home with families and carers providing positive feedback that they are happy with the accommodation and care being provided.

> the transition team was also successful in transitioning 15 residents to a number of mainstream residential aged care facilities. A comprehensive multidisciplinary process was undertaken to determine the suitability of residents for an aged care facility and then each was matched with a facility that met their needs, preferences and requirements. This involved extensive consultation with families and carers.

> the Oakden Transition Team is now considering suitable options for the ongoing care of a number of residents at Clements House. This will enable the complete decommissioning of the Oakden campus by the end of 2017.

Coronial findings

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

A report to the Coroner on actions taken in response to recommendations is provided within six months from the date of the findings being handed down. During 2016-17 the Coroner delivered 13 findings of inquest resulting in a total of 31 recommendations relevant to the health portfolio. The following provides a case study of two inquest findings and the subsequent actions reported by SA Health to the Coroner.

Coronial Inquest 1 – Continuity of Care

An inquest was held into the death of a child as a result of multi-organ failure secondary to overwhelming herpes simplex infection. The Coroner concluded that no single medical professional had an opportunity to observe the progress of the patient's illness and was critical of there being a lack of continuity of care.

The inquest resulted in a recommendation that the Women's and Children's Hospital consider the implementation of a campaign to inform parents of the importance of continuity of care, and the risks involved in breaking that continuity, with a view to encouraging parents to return to the Women's and Children's Hospital if they have any doubts about subsequent care, regardless of whether they believe the child is getting worse, or merely not getting better.

The Women's and Children's Health Network (WCHN) plans to implement the "Ask Me to Explain" campaign in the Paediatric Emergency Department (PED). This includes resources for patients and consumers, staff education and an awareness campaign to promote continuity of care.

The objective of the campaign is to improve communication between PED staff (medical, nursing, clerical and other support staff) with the child and their parent/carer through encouraged discussion and transparency of information.

The campaign will identify:

> barriers to effective communication between clinicians and consumers

> themes that questions are to be based on following identification of barriers

> key questions for consumers to ask staff and key questions for staff to ask consumers focusing on three key themes: diagnosis, discharge plan/care and concerns.

WCHN is developing artwork to support the campaign and a communication strategy for consumers and PED staff. The campaign will be promoted across WCHN and is planned to commence in January 2018.

The implementation of the campaign will be monitored by the Division of Paediatric Medicine leadership team through monthly review with the Chief Operating Officer and six monthly reviews at the WCHN Clinical Safety and Quality Committee. Staff and consumer feedback will be obtained to determine the effectiveness of the campaign.

In addition, WCHN has updated the 'Paediatric Emergency Department Patient Discharge Information' form. The objective is to improve awareness and communication to consumers on discharge plans, follow up care needs and when to seek further medical assistance.The form has been updated to include the following: "if your child's condition does not improve or worsens, call an ambulance or return to the Emergency Department".

Coronial Inquest 2 – Death following laparoscopic bariatric surgery

An inquest was held into the death of a person aged in their thirties as a result of hypoxic-ischaemic encephalopathy following laparoscopic bariatric surgery with iatrogenic spleen and liver damage on a background of ischaemic heart disease, obesity and obstructive sleep apnoea. The Coroner concluded that the death was preventable and was the result of a lack of proper nursing care in the high dependency unit of a private hospital.

The Coroner recommended that the Minister for Health ensure that nursing staff throughout the State are given refresher training in the proper use of pulse oximetry monitoring equipment, including training about the need to ensure that low readings are not wrongly assumed to be erroneous, and the proper use of the plethysmograph wave form in determining the reliability of the SpO2 data shown on the monitor.

Local Health Networks (LHN) Executive Directors of Nursing and Midwifery developed local action plans to address the recommendation and ensure that training continues to be provided to nursing staff and higher acuity areas in the proper use of pulse oximetry monitoring equipment, including the use of the plethysmograph and reliability of SpO2 data. This will be provided through a range of mechanisms including induction programs, foundational and clinical assessment programs, onsite practical sessions provided by product representatives and online educational packages.

The Chief Nurse and Midwifery Officer, Department for Health and Ageing met with the SA Private Hospitals Director of Nursing (DON) Committee to discuss the findings. All private hospital DONs are developing education packages for proper use of pulse oximetry monitoring equipment, which can tailor the education and competency assessments to clinical areas.

In addition, The Chief Nurse and Midwifery Officer met with the Deans of the Schools of Nursing and Midwifery of the three major South Australian Universities to discuss this case being used to educate nurses and midwives both pre and post registration.

Partnering with Consumers and the Community

Over 700 South Australians partner with SA Health in service planning, designing care, measuring and evaluating health care services.

In total over 15,000 South Australians have been interviewed over the telephone and **over 2,300 were surveyed in 2016**.

Over 2,700 consumers surveyed on their experience in the health service using a **computer assisted personal interview (CAPI) mobile device**.

Over 6,600 consumers participated in **Happy or Not**, monitoring satisfaction on quality of care and performance.

Over 600 "Do you need an interpreter?" posters, guides and interpreter symbols have been displayed in health sites.

Over 4,000 "please arrange an interpreter" wallet cards have been given out to culturally and linguistically diverse consumers.

Over 6,000 Partnering with Consumers and Community **online eLearning course** completed by staff.

Consumer engagement

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

The SA Health Partnering with Consumers and Community Advisory Group continues to work as the strategic committee for partnering with consumers. Work is underpinned by the Australian Safety and Quality Framework in Health Care, and National Safety and Quality Health Service Standards, and aligns with the SA Health Framework for Active Partnership with Consumers and the Community.

Highlights:

- Northern Adelaide Local Health Network (NALHN) hosted a Partnering with Consumers and Community Forum in May 2017.
- In 2016-17, over 25 statewide consumer information sheets / brochures were reviewed and endorsed by the SA Health Safety and Quality Community Advisory Group.

SA Health Partnering with Consumers and Community Advisory Group representation includes Health Consumers Alliance SA, Health and Community Services Complaints Commissioner, Consumers, Local Health Network representatives, Drug and Alcohol Service (DASSA), SA Ambulance Service (SAAS) and SA Health representatives from Mental Health and Substance Abuse, Nursing and Midwifery Office, Service Development and Safety and Quality Unit.

In 2016-17, the Partnering with Consumers and Community Strategic Action Plan continued to work on measuring consumer experience, partnering with carers, consumer feedback and patient rights and engagement. The proposed National Safety and Quality Health Service Standards 2nd Edition were reviewed and aligned to the strategic action plan.

Partnering with Consumers Forum

In May 2017, the Northern Adelaide Local Health Network (NALHN) Consumer Advisory Committee hosted the first Partnering with Consumers and Community Forum at Modbury Hospital.

The forum included:

> A tour of the new Rehabilitation Centre at Modbury Hospital

> Show case presentation from the NALHN Consumer Advisory Committee

> A family's experience presentation from a local northern consumer

> Transforming Health update

Picture 3: Forum participants tour of the new Rehabilitation Centre at Modbury Hospital

Participant's evaluation of the forum was positive and feedback included:

"I enjoyed meeting with other participants and learning a little bit more about NALHN and their place in the SA Health system. I really enjoyed the tour of the new rehab facility, state-of-the-art and I can imagine rehabilitation in this wonderful area would be inspirational."

"NALHN Consumer Advisory Committee report and resources was excellent."

"All very interesting and very informative – thank you for organising."

Partnering with Carers

Picture 4: Margaret and Antonio sharing their story on SA Health facebook

Following the release of the SA Health Partnering with Carers Policy Directive in October 2015, the SA Health Safety and Quality Unit continues to collaborate with Carers SA.

During National Carers Week in October 2016, posters were displayed in health sites.

SA Health celebrated South Australian carers by sharing their stories on our social media channels.

Facebook reached over 45,700 people, and Twitter had over 8,500 impressions.

The SA Health Partnering with Carers Strategic Action Plan and key priorities are in development.

Consumer Advocacy Training

SA Health Safety and Quality presents the national and state agenda for Partnering with Consumers and Community Program, as part of the Health Consumers Alliance (HCA) SA Consumer Advocacy Training. The Safety and Quality presentation outlines consumer engagement, consumer experience and feedback, patient rights and public reporting.

The purpose of the training is to improve knowledge about consumer centred care, consumer engagement in health and how it improves the safety and quality of health services, as well as provide some practical tips for effective consumer advocacy.

In 2016-17, over 70 consumers participated in the Consumer Advocacy courses, including one in Berri, one in Nuriootpa and one for Aboriginal Experts by Experience. Consumers who participate in the training are already engaged with an LHN or service, and others participate in the training and then go on to engage in services and apply for consumer roles. Other participants include people representing non-government health services, mental health and research organisations.

Country Health SA participants included both Health Advisory Council (HAC) members and consumer representatives, and had the highest number of training with 29 people completing the training. Eighteen participants attended from across the Riverland in February 2017.

Picture 5: Participants in the HCA Consumer Advocacy training in Berri

Consumer feedback

SA Health encourages patients, consumers, families, carers and the community to provide feedback.

Whether it's good or bad, feedback from patients/consumers, families, carers and the community is vital in improving the quality of service we provide.

Highlights:

- Your feedback is important information sheet was reviewed and presented in a more consumer friendly format.

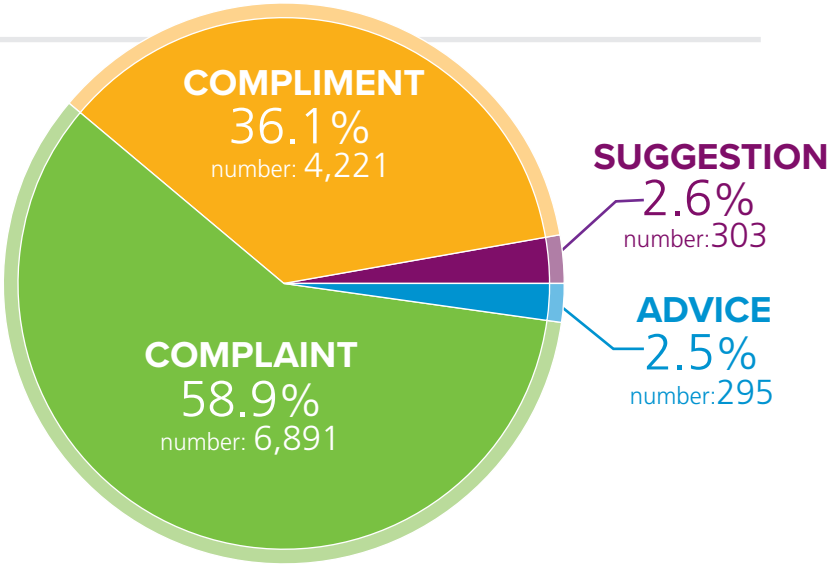
Feedback provides an opportunity for health services to observe the quality of health care from the perspective of patients, consumers, families, carers and the community. It also assists in directing improvement in the quality of these services.

The SLS Consumer Feedback module is used to record all complaints, compliments, advice and suggestions in South Australia.

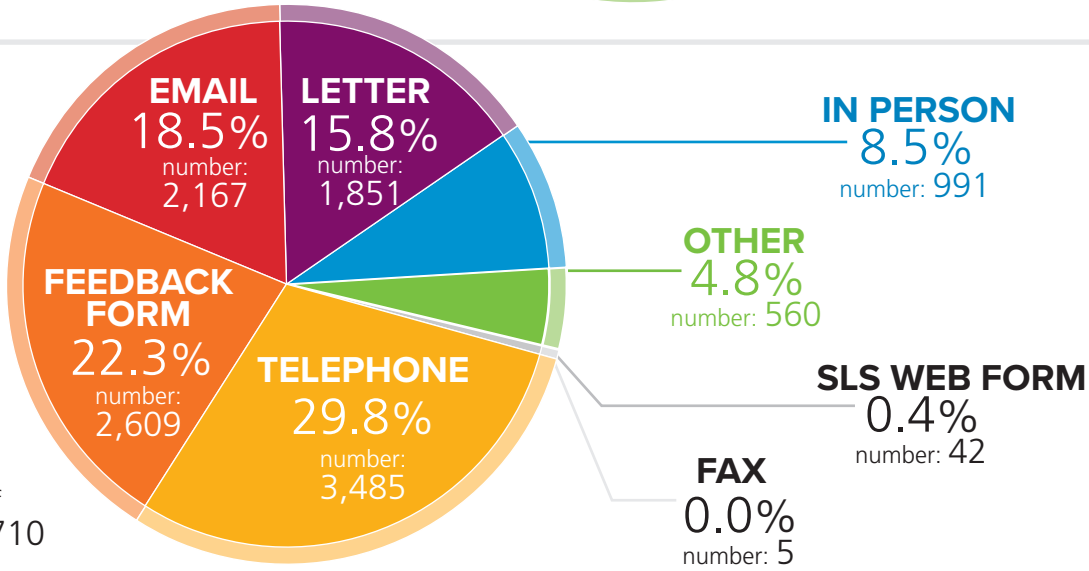
Between 1 July 2016 and 30 June 2017, 11710 records of consumer feedback were reported into the SLS, a 4.9% increase from 2015-16 (n=11,167).

Type of consumer feedback

Total number of feedback: 11,710



Method of feedback



Total number of feedback: 11,710

Classification of complaints by national health complaints categories

Complaints are classified against the national health complaints categories and sub categories. Between 2016-17 there was a 2% increase in the number of complaints in relation to treatment, a 3% decrease in complaints received on communication and a 1% decrease in relation to access.

Classification	2016-17	2015-16
Treatment	28.2%	27.7%
Communication	26.0%	26.8%
Access	22.6%	23.0%
Corporate service	9.9%	10.2%
Cost	3.9%	3.7%
Privacy / discrimination	4.8%	4.1%
Professional conduct	2.2%	1.9%
Grievances	1.1%	1.5%
Consent	1.2%	1.1%
Total	**100%**	**100%**

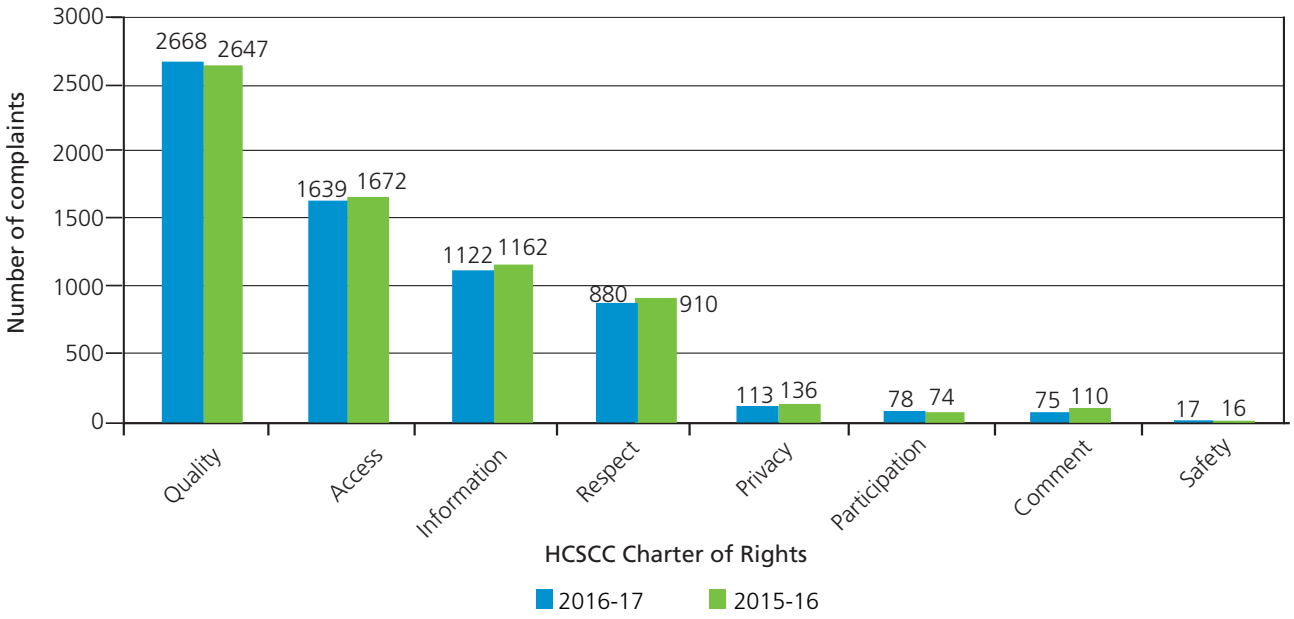
Complaints aligned to the HCSCC Charter of Rights

The SA Health Charter of Health and Community Services Rights Policy Directive implements the Charter of Health and Community Services Rights (the HCSCC Charter). The policy aims to increase the awareness of all staff, consumers, families, carers and the community about their rights 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 SLS Consumer Feedback module. The graph below highlights that quality of care, access and information and respect are areas of complaints which are mostly received from consumers. Fewer complaints are received about privacy, participation, comment and safety.

Between 2016-17 and 2015-16, there was a 1% increase in the number of complaints reported which align to the Charter of Rights in relation to quality. Complaints in relation to access have decreased by 2%, and there was a 3% decrease in relation to information.

Graph 4: SA Health complaints aligned to HCSCC Charter of Rights 2015-17



Consumer feedback process

As part of the consumer feedback awareness program, the "Your feedback is important" information sheet has been developed to replace the 'consumer feedback process' information sheet.

The information sheet is presented in a consumer friendly format encouraging feedback from all our consumers including patients, consumers, families, carers and the community. The information sheet provides a step-by-step process for providing feedback, and a list of health site contacts and telephone numbers is provided on the back page.

The information sheet is available on the Health and community services feedback and complaints page on the SA Health website www.sahealth.sa.gov.au.

Your feedback is important

We encourage patients, consumers, families, carers and the community to provide us with feedback.

We want to hear what is good, what is bad and what we can do to make the health care services better.

Consumer feedback and raising concerns provide an opportunity to observe the quality of health care from the perspective of all patients and consumers. It also assists in directing improvement in the quality of health services.

In the first instance, please talk to a staff member at the point of care.

If you feel your feedback or concern has not been resolved, a list of health site contacts and telephone numbers is provided on the next page.

Step 1

Talk to a staff member

If you would like to provide feedback or raise a concern, please talk to a staff member looking after you or your loved one.

Step 2

Contact the Consumer or Patient Adviser

If you feel that your feedback or concern has not been resolved, you can contact the Consumer or Patient Adviser at the health care service. (See next page)

Step 3

Seek an independent opinion

If you are not happy with the health care service response to your feedback or concerns, you can contact the Health and Community Services Complaints Commissioner on (08) 8226 8666 or 1800 232 007 (Toll free Country SA landline).

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

Measuring consumer experience

SA Health is working to deliver the best possible health services and patient/consumer experience. We are committed to ensuring that every patient's needs, values and preferences are respected.

Each year we talk to more than 2000 South Australians on the telephone to find out about their overnight hospital stay in a public city or country hospital. We ask them about all aspects of their stay. This includes how they were treated, their role in decision-making, hospital cleanliness, food quality, discharge information and their privacy.

The SA Consumer Experience Surveillance System (SACESS) survey feedback shows us what we're doing well and where we need to improve. It is also a great way for us to compare our care with other hospitals around Australia.

The Measuring Consumer Experience infographic on the next page, outlines our performance benchmarks, where we met 6 out of 10 care domains.

A statewide Strategy for Improvement Report on the domains of care under the SA Health benchmark of 85 has been developed.

All qualitative comments from SACESS are reviewed by the Local Health Networks on a monthly basis. In 2017, Measuring Consumer Experience Infographics were developed for all Local Health Networks.

The full Measuring Consumer Experience Report, Community Report and infographic are available on the SA Health website at www.sahealth.sa.gov.au/safetyandquality.

The majority of our patients continue to be happy with their level of care

93%

felt they were **TREATED** with **RESPECT AND DIGNITY** during their stay.

87%

said they would **RECOMMEND THE HOSPITAL** to a relative or friend.

ALMOST

88%

RATED the overall quality of the hospital care as **'VERY GOOD' or 'GOOD'**


MEASURING CONSUMER EXPERIENCE
In 2016 SA Health surveyed more than 2,300 consumers to find out more about their public hospital experience.
The 58 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
93% of consumers felt that they were TREATED with RESPECT & DIGNITY AT ALL TIMES
CONSISTENT AND COORDINATION OF CARE
35% GOT CONFLICTING or INCONSISTENT INFORMATION from staff
FOOD
APPROXIMATELY 22% thought they DIDN'T get enough HELP at mealtimes
NURSES & DOCTOR
OVER 90% of consumers TRUSTED their doctors and nurses
PAIN
91% felt that staff did everything they could to control their pain
CLEANLINESS
NEARLY 90% felt that hospital facilities and staff were CLEAN
INVOLVEMENT IN DECISION MAKING
NEARLY 19% thought they weren't getting enough INFORMATION about their condition or treatment
PRIVACY
OVER 90% were GIVEN enough PRIVACY during discussions and examinations
DISCHARGE INFORMATION
APPROXIMATELY 36% of consumers weren't given written information about what they should or shouldn't do after leaving hospital
SOME 87% OF CONSUMERS WOULD RECOMMEND THEIR HOSPITAL TO A FRIEND OR RELATIVE
FIND OUT MORE BY VISITING: www.sahealth.sa.gov.au/safetyandquality
Government of South Australia
SA Health

We are listening to our consumers and community

In 2016-17 we continue the Measuring Consumer Experience Computer Assisted Personal Interview (MCE CAPI) Program, using mobile devices.

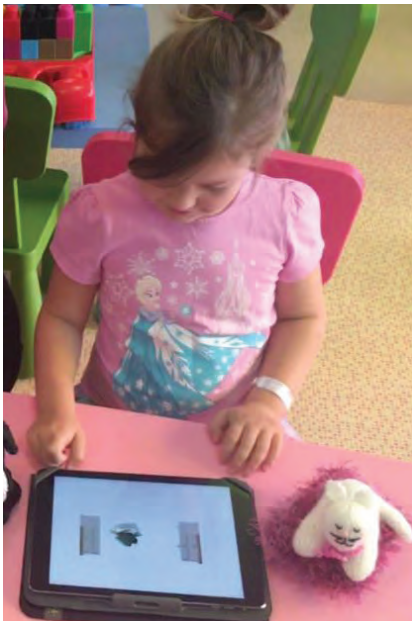
MCE CAPI helps to give everyone a chance to share their experience. Surveys can be tailored to specific patient populations such as Aboriginal and Torres Strait Islander communities, Culturally and Linguistically Diverse (CALD) patients, those with a special condition, maternity and children, and those with a lived experience.

Children can share their story with Fabio the frog, an animated character that helps them engage with the survey. People can also read or hear the survey in their own language.

The Northern Adelaide Local Health Network Paediatrics Unit undertook a number of surveys in the Children's Ward at Lyell McEwin Hospital including:

> General medical survey for children, young people, parents and carers.
> Short stay survey for parents and carers
> Paediatrics survey for children and young people
> Special Care Nursery survey for parents and carers

Picture 6: Children sharing their story Fabio the frog



In 2016-17, over 2711 consumers were surveyed in the MCE CAPI program including:

> over 45 children and young people in NALHN Paediatrics
> over 65 parents and carers NALHN Paediatrics
> over 255 women and mothers from Women's and Children's Health Network including allied health, Children and Family Health Services (CaFHS), paediatric department and Women's and Babies Service (WABS)
> over 1,000 rehabilitation inpatients
> over 275 rehabilitation at home patients
> over 400 Drug and Alcohol Services SA clients

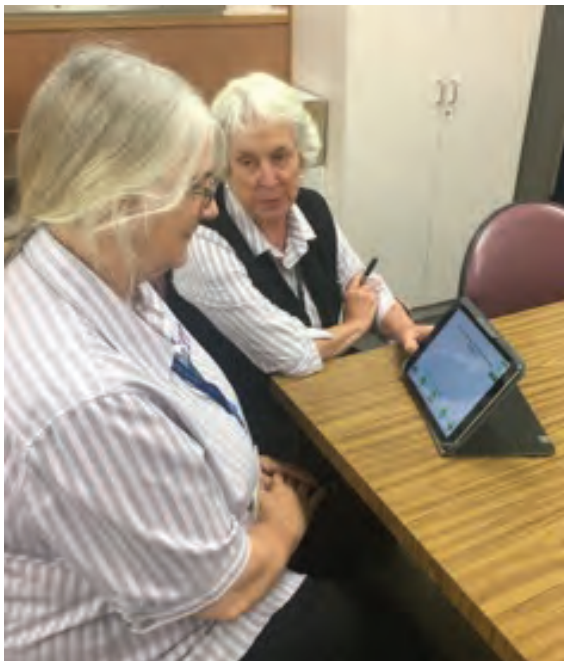
> over 60 patients attending physiotherapy

> over 50 patients in cancer services

> over 169 patients attending intermediate care services

> over 175 patients attending outpatient departments

MCE CAPI surveys were also undertaken in mental health services and cardiology and online surveys completed in SA Dental Service and SA Ambulance Service.



Picture 7: RAH volunteers

MCE CAPI Volunteer training

In 2016-17, a number of Lavender Lads and Ladies Volunteers at Royal Adelaide Hospital (RAH) were trained as surveyors in the MCE CAPI Program.

Volunteers assist patients to complete the surveys using a mobile device.

Royal Adelaide Hospital patients were interviewed in areas including:

> Outpatients

> Cancer services

> Physiotherapy department

Mental Health Services – National Your Experience of Service "YES" Survey

The SA Health Safety and Quality Operational Governance Committee, Chief Psychiatrist, and the Strategic Mental Health Quality Improvement Committee endorsed the statewide rollout of the National Your Experience of Service 'YES' – Australia's National Mental Health Consumer Experience of Care Survey.

Over 230 people with a lived experience completed the YES survey during 2016-17, this also included promotion of the YES survey during Mental Health Week from 9 to 15 October 2016.

Quality improvement action plans were developed by the LHN Mental Health Services. The YES statewide report were presented and discussed with the Office of the Chief Psychiatrist Lived Experience Group to identify strategies for improvement.

In 2017-18, Local Health Networks will continue to roll out the YES survey.

A new approach to capturing your consumer experience

In 2016-17 a total of 6,644 consumers provided their experience using the HappyOrNot smiley terminals.

Picture 8: Smiley terminals

SA Health piloted the HappyOrNot Smiley terminals which report on patient satisfaction by asking one question on their experience, service delivery and quality of care.

The terminals give consumers a voice to convey their experience, enables monitoring and continuous improvements, and the ability to implement strategic changes in a more timely fashion.

Clear and timely reporting enables health care sites to drill down to hours or days of service delivery, and enables health care sites to set goals, see fluctuations, monitor, implement changes, and identify target areas for improvement.

Pilot sites included Flinders Medical Centre – Cancer Clinic and Outpatient Department, Repatriation General Hospital Outpatient Department and the Emergency Department at Lyell McEwin Hospital

In 2017-18, the terminals will be placed in the Women's and Children's Hospital Emergency Department, and other health care services throughout the state.

Further information on Partnering with Consumers and the Community is available on the SA Health Safety and Quality website at www.sahealth.sa.gov.au/safetyandquality.

Improved support for people who do not speak English

Culturally and Linguistically Diverse (CALD) resources

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.

CALD resources were developed by the SA Health Safety and Quality Community Advisory Group, SA Health Culturally and Linguistically Diverse Consumer Experience Advisory Group and endorsed by Multicultural Communities Council SA (MCCSA).

The CALD resources make it easier for patients / consumers to request an interpreter, and help staff when arranging an interpreter for the patient/consumer, to ensure that the interpreter is provided in their preferred language and dialect.

During August and September 2016, the CALD resources were implemented statewide in all health sites, following a pilot of the resources in 2015-16. The CALD resources are displayed in main foyer entrances, reception areas, emergency departments, admission centre, outpatient departments, day surgery units and wards.

Interpreter card

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

National interpreter symbol

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.

Do you need an interpreter? poster

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."

Poster 1 (left) includes the list of countries and flags based on the top 20 communities who accessed SA Health.

Poster 2 was developed following the pilot to include the list of countries and flags based on top 15 new and emerging communities who accessed Women's and Children's Health Network.

A guide to using the CALD resources and staff information sheet on the CALD resources have also been developed as part of the implementation.

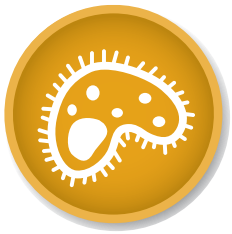
An evaluation following the pilot of the CALD resources was undertaken and positive feedback was received by the LHNs. Feedback included:

> *"It was easier having the picture of the flags".*

> *"It was a very useful card for our clients. Staff felt a good opportunity to talk to clients as their right to request an interpreter. Clients find the cards useful, as it also shows the need for interpreter and language required".*

> *"Yes all sites reported an increase in staff and consumer awareness of interpreter services as a result of the pilot".*

Infection control and prevention



The Infection Control Service section of the Communicable Disease Control Branch is responsible for the provision of best-practice advice on infection prevention and monitoring of healthcare-associated infection. The service is also responsible for the ongoing development and management of the Commonwealth-funded National Antimicrobial Utilisation Surveillance Program (NAUSP), which collects information on the rates of usage of antimicrobials in over 200 Australian hospitals.

Priority areas

> Statewide infection prevention and control policy and guideline development and updating according to current best practice, in order to reduce practice variation and minimise the risk of infection associated with the receipt of health care treatment.

> Monitoring the statewide implementation of the revised standard for sterilisation and reprocessing of reusable medical devices (AS/NZ 4187: 2014) ensuring best practice in this specialised field is maintained.

> Maintaining the statewide healthcare-associated infection surveillance program and provision of relevant reports containing analysis of surveillance data.

> Development of a suite of statewide antimicrobial prescribing guidelines and associated tools to improve the appropriate use of antibiotics and antifungal agents in all South Australian public hospitals and community health care settings.

> Further development and maintenance of the NAUSP database and provision of antimicrobial usage surveillance data analysis and reporting.

What's new

The Infection Control Service has developed a number of new statewide policies and clinical practice guidelines during 2016-17 including:

> Cystic fibrosis: infection prevention and control clinical guideline.

> Microbiological testing of endoscopes clinical guideline.

> Peripherally inserted central catheter (PICC) dressing management clinical guideline.

> Reprocessing of reusable medical devices clinical directive.

> Empirical treatment of bacterial UTI (adults) clinical guideline.

> Community-acquired pneumonia (adult) clinical guideline.

> Febrile neutropenia management (adult) clinical guideline.

> Splenectomy vaccination and antimicrobial prophylaxis (adult asplenic and hyposplenic patients) clinical guideline.

Several consumer information sheets were also developed in 2017, including:

> Antibiotic consumer information sheet containing information for patients and carers on antibiotic medicines used in hospital.

> Two consumer information sheets on preventing infections: in hospital settings and in community healthcare settings.

> Generic "visitor alert" posters to help manage outbreaks of seasonal illnesses such as gastroenteritis or influenza.

The consumer information sheets were reviewed and endorsed by the SA Health Safety and Quality Community Advisory Group.

Information on healthcare associated infections is provided to patients, carers, consumers and service providers via the Hospital infections page or the SA Health website for Infection Prevention at www.sahealth.sa.gov.au/infectionprevention.


SA Health Consumer Information
Infection Prevention and You
You are an important part of preventing an infection while you are in hospital
BEFORE ADMISSION
REPORT any recent infections, especially if you are still on antibiotics.
STOP smoking before surgery as this increases the risk of infection.
IN THE HOSPITAL
ASK your healthcare worker if they have cleaned their hands.
AVOID touching any wound or medical device (if present).
WASH your hands after using the toilet or a commode, and before eating.
COVER your mouth & nose with a tissue or your elbow when coughing or sneezing.
TELL your nurse if your wound or skin around a medical device becomes red, swollen or painful.
KEEP your dressings clean and dry. Inform your nurse if not secure.
DO NOT ENTER
DISCOURAGE friends and family from visiting if they are unwell.
ON DISCHARGE
TAKE the full course of any antibiotics prescribed, even if you feel better.
FOLLOW instructions regarding the care of your wound or medical device.
Take action for preventing infection
Visit the website for more information:
www.sahealth.sa.gov.au/hospitalinfections
This document has been reviewed and endorsed by SQCAG* for consumers and the community March 2016.
*SA Health Safety and Quality Community Advisory Group.
Government of South Australia
SA Health

Other significant achievements

Between 2016-2017 significant upgrades occurred to the NAUSP database with development of an online portal for data entry, improvement of benchmarking options for hospitals, and the ability for contributors to load and extract data for specialty areas such as cancer wards.

NAUSP Annual Report 2016 – data from 169 hospitals (21 South Australian hospitals) showed that overall hospital rates of usage has declined since 2011 when the National Safety and Quality Health Service Standards were introduced.

Healthcare-associated infection surveillance annual reports – two reports were published for 2016: *Bloodstream infection and multi-drug resistant microorganisms*.

Outcomes

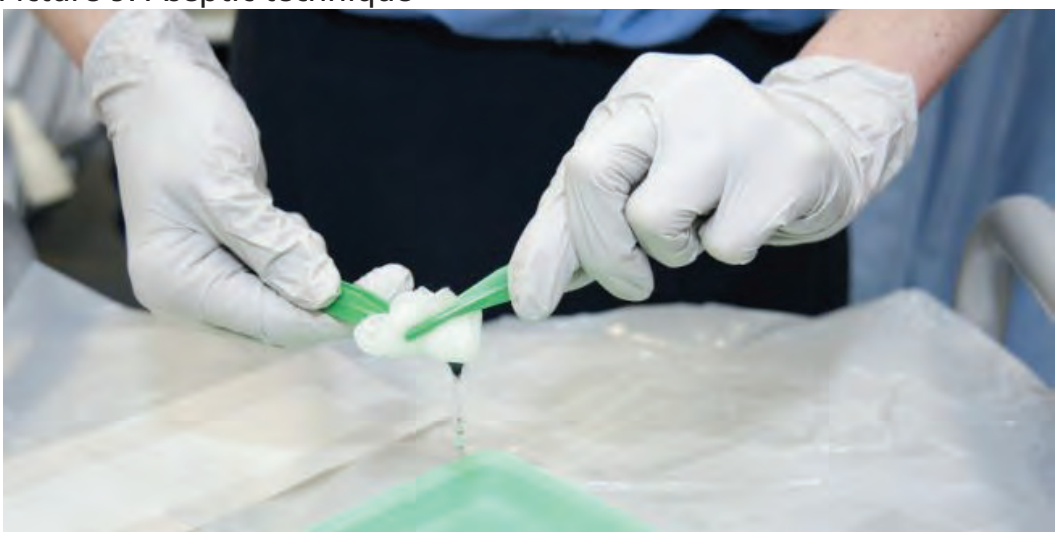
Data from the healthcare associated infection surveillance program showed that bloodstream infection rates in SA public hospitals remained at similar levels to the previous reporting period. The aggregate rate of healthcare-associated bloodstream infection was 4.5 cases per 10,000 patient-days for 2016.

28% of these were associated with an indwelling medical device and were therefore potentially preventable. Work on improving medical device management continues to be a high priority.

The rate of infection with key antibiotic-resistant micro-organisms has also remained similar to the previous year. There has been a small decline in the rate of infection due to methicillin-resistant *Staphylococcus aureus* (MRSA), whilst infections due to multi-drug resistant Gram-negative bacteria and vancomycin-resistant enterococci (VRE) have remained relatively stable.

Data from the NAUSP showed that the average antibacterial usage rate for SA hospitals was higher than for Victoria and Western Australia, but lower than other states and territories, and lower than the national average. Usage rates of broad-spectrum carbapenems, used to treat infections caused by some antibiotic-resistant organisms, were lower than all Australian states and territories except Queensland.

Picture 9: Aseptic technique



Medication safety

SA Health is committed to improving the safety and quality of medicines use to promote optimal patient outcomes through enhanced medicines management. The priority areas for medication safety in SA Health are aligned to the National Safety and Quality Health Service (NSQHS) Standard 4 Medication Safety.

High risk medicines

High risk medicines are acknowledged as those medicines which have an increased risk of causing harm when used in error. Mistakes are not necessarily more common with these medicines; however, the consequences of an error can be more devastating. 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.

Medication incidents are reported to the SLS. To assist LHNs and hospitals to identify incidents relating to high risk medicines, a suite of standard reports has been developed for SLS under the APINCHEN acronym:

A = anti-infectives (Ap = psychotropics)
P = potassium and other electrolytes
I = insulin
N = narcotics and sedatives
C = chemotherapeutic agents
H = heparin and anticoagulants
E = epidural and intrathecal agents
Ne = neuromuscular blockers

Reports can be run for each individual category or for all high risk medicines. LHNs regularly review the incidents to inform improvements for patient safety.

Highlights:

- Developed a standard suite of reports for the SLS for high risk medicines.
- Supporting patient safety and continuity in medication management through a standard Interim Medication Administration Chart for patients discharged to residential care facilities.
- Promoting medication and patient safety in the treatment of cancer, use of psychotropic medicines and electronic medication management systems.
- NALHN launched the Pocket DTC mobile application.

Picture 10: Staff providing consumers information on the use of medications

Continuity in medication management

One strategy to improve continuity in medication management when a patient is discharged from an acute hospital to a residential care facility is to provide an Interim Medication Administration Chart (IMAC). Whilst SA Health hospitals have provided variable examples of an IMAC, a standard IMAC has been developed to support consistency across sites and enables continuity in medication management. The standard IMAC includes the patient's current medicines and supports documenting administration for up to seven days.

The chart is based on the principles of the National Inpatient Medication Chart (NIMC) and includes current adverse drug reaction (ADR) information. Use of an IMAC has been shown to enhance quality use of medicines and continuity of patient care by providing accurate, up-to-date and timely medicines information and reducing the potential for missed, unnecessary and duplicate doses in the period immediately post discharge.

Medication Safety Alerts and Notices

Medication Safety Alerts provide important safety information to healthcare professionals and services across the South Australian health system. Each alert specifies action to be taken by health services, the timeframe in which such action must occur and specific responsibility for the actions.

In 2016-17, the following alerts and notices were distributed:

- Glyceryl trinitrate tablets – safety update regarding time to dissolve
- Medicine shortage – etoposide phosphate powder for injection
- Glyceryl trinitrate tablets – new strength and brand
- Elastomeric infusor devices for medication administration
- National shortage of intravenous fentanyl
- Urgent update – national shortage of intravenous fentanyl

New committees promoting medication safety

Three new committees were established as sub-committees of the South Australian Medicines Advisory Committee (SAMAC); the SA Health Cancer Drug Committee, the South Australian Psychotropic Drugs Committee, and the South Australian Electronic Medication Management Committee (SAEMMC).

The SA Health Cancer Drug Committee (SAHCDC) was established in 2016 to support patient safety by providing overarching governance to promote quality use of chemotherapeutic medicines. The primary focus is ensuring the chemotherapy prescribing protocols and decision support tools are regularly reviewed and supported by the most up to date evidence. The first output of the Committee was to implement a statewide process for the development, approval and regular review of cancer chemotherapy protocols within SA Health and the monitoring of single-use protocols where treatment options are limited for individual patients (eg. rare cancers, patients unable to tolerate standard treatment due to other factors). The approved SA Health protocols will be available as a chemotherapy register on a dedicated web page.

The South Australian Electronic Medication Management Committee (SAEMMC) was established in 2017 to provide clinical governance, support the quality use of medicines and optimise medication safety for electronic medication management systems in use within SA Health.

The South Australian Psychotropic Drugs Committee (SAPDC) was established to provide independent advice to professions prescribing psychotropic medicines on rationale, use and practices related to pharmacological agents used in the treatment of psychiatric illness in South Australian health services. One of the roles of the committee is to improve patient safety by supporting the reduction of adverse medication events in mental health services.

An eLearning module for the safe prescribing and administration of the high risk medicine clozapine has been developed under the oversight of the committee.

The High Risk Medicines: Clozapine eLearning module will be released in 2017-18.

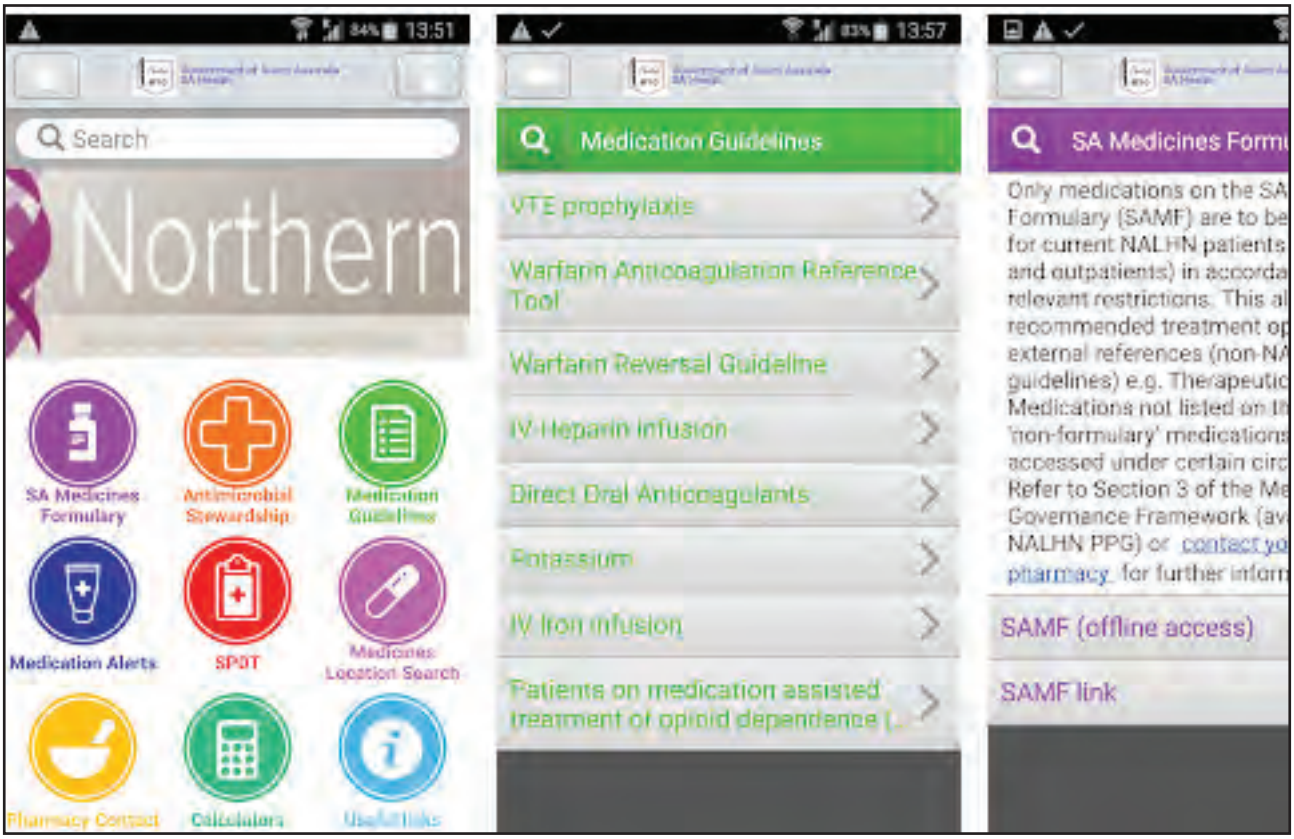
Picture 11: High Risk Medicines Clozapine eLearning module

Innovation and highlights

Pocket DTC® mobile application

Northern Adelaide Local Health Network (NALHN) Drug and Therapeutics Committee (DTC) has recently launched the 'Pocket DTC' mobile application on iTunes App Store and Google Play Store for use on clinician's mobile devices. The app provides timely access to up-to-date information and contains a search function for the South Australian Medicines Formulary, NALHN medication policies and guidelines, links to medication related resources and other useful resources.

Picture 12: Pocket DTC app



Medication Administration Guideline workgroup

The Medication Administration Guideline (MAG) workgroup reports to NALHN DTC and was established to review and develop NALHN-wide adult medication guidelines where currently approved medication resources either do not provide sufficient detail or there is a need for NALHN specific information.

Venous Thrombo-Embolism Prophylaxis

Following an audit of Venous Thrombo-Embolism (VTE) risk assessment and appropriateness of therapies for admitted patients at the Lyell McEwin and Modbury Hospitals, action plans have been developed to support improvement in appropriate care. NALHN DTC is scoping the development of an e-learning package to assist clinician's understanding of VTE assessment and appropriate prophylaxis treatment.

Blood and blood products

Blood and blood products are a vital resource, made available through the generosity of donors. While the use of blood and blood products can be lifesaving, there are also risks associated with their administration.

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

Blood Organ and Tissue Programs (BOT) in SA Health is responsible for the coordination of the national supply planning process for blood and blood products for South Australian public and private hospitals. The Unit facilitates the development of statewide policies, procedures and protocols relating to the utilisation of products, within national guidelines, through the SA Blood Management Council ("the Council").

The Council is the peak state advisory body on blood sector matters and has the responsibility of taking a strategic statewide lead on blood management activities.

During 2016-17, the Council supported the establishment of patient blood management projects across South Australia. The projects were nominated by medical, nursing and research staff in the public, private and primary care settings.

The priority project areas included:

> anaemia management strategies; referral processes, linkages with out-of-hospital/ community care, elective surgery pathways and sustainable models for services
> minimising patient blood loss through surgical techniques, devices and haemostatic agents and the use of cell salvage in evidence-based indications
> expanding the role of nurses in Patient Blood Management activities
> developing clinical policies, procedures, algorithms and tools with appropriate adaption to local needs and patient groups.

BloodSTAR

SA Health was the second jurisdiction to implement the National Blood Authority's BloodSTAR online management system for tracking prescriptions, authorisations and reviews of immunoglobulin therapy. The purpose of the system is to standardise and manage access to the supply of immunoglobulin products for the treatment of conditions identified in the Criteria for the Clinical use of Intravenous Immunoglobulin. Currently, 497 doctors and 186 nurses are registered to use the new system.

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. In 2016-17, BloodSafe nurses continued to undertake regular audits of transfusion episodes, principally to assess documented consent and appropriate use.

Managing blood and blood product safety

In 2016-17 SA public and private health service organisations implemented and strengthened systems to safely and efficiently receive, store and transport blood and blood products while maintaining and expanding access and minimising wastage.

BloodSafe eLearning Australia

BloodSafe eLearning Australia (BEA) develops and delivers nationally funded online education courses designed to provide knowledge of patient blood management (PBM) and safe transfusion practice to healthcare professionals in order to improve patient outcomes. BEA, hosted by the Digital Media Unit, Women's and Children's Health Network, received recognition during the year with the program awarded Runner-up at the International eLearning Awards. A team member was also awarded the Excellence in Innovation in Education at the South Australian Nursing and Midwifery Excellence Awards.

In 2016-17, BEA delivered:

> Three new courses, based on the national PBM Guidelines: Module 5 Obstetrics and Maternity. Courses include; Obstetric Haematology, Obstetric Blood Management and Postpartum Haemorrhage.

> Updates to the Clinical Transfusion Practice, Collecting Blood Specimens and Transporting Blood courses.

> 425,000+ learners registered and 850,000+ courses completed by 30 June 2017.

BloodMove

BloodMove projects continue to meet program objectives by reducing red cell and platelet wastage rates to ensure an effective supply and usage of emergency blood in South Australian metropolitan and regional centres.

Country Health SA Local Health Network (CHSALHN) achieved zero blood wastage for four months of the year and the CHSALHN BloodMove Team was awarded the SA Health Nursing and Midwifery Excellence award for Person Centred Care.

In 2016-17 BloodMove also:

> developed a new split system Massive Transfusion Protocol shipper for the private sector allowing more efficient transport and temporary storage of mixed temperature products (red cells and platelets) to improve safety and reduce wastage

> assessed the safety of the pneumatic tube systems for the transport of blood and products in the new Royal Adelaide Hospital and The Queen Elizabeth Hospital
> facilitated South Australia achieving the lowest red cell discard rate of all Australian jurisdictions at 1.4% for the year (compared with the national average of 2.3%) and the lowest platelet discard rate at 7.1% (compared with the national average / of 12.3%).

National Patient Blood Management Collaborative

The aim of the National Patient Blood Management Collaborative, sponsored by the Australian Commission on Safety and Quality in Health Care (ACSQHC), was to improve the assessment and management of anaemia and iron deficiency across participating sites and improved integration of care between primary and acute service systems. SA Health's contribution to the Collaborative was through NALHN (multiple surgical streams) and Women's and Children's Health Network (WCHN) (gynaecology) participation.

As part of the Collaborative, participants:

> developed a patient blood management care plan to assist in the coordination, communication, documentation of planning and implementation of pre-operative patient blood management
> promoted patient blood management initiatives within NALHN through coordination of education sessions
> NALHN Division of Anaesthetics and Surgical sub-specialties partnered with Northern Health GP Network to work in collaboration with the assessment and management of category 2 and 3 patients on the elective surgery waiting list
> promoted IV iron infusion services in the community and within the LHN
> submitted information into the Collaborative on challenges, achievements and outcomes.

The experiences of the 12 participating health services across Australia are showcased on the Australian Commission on Safety and Quality in Health Care's website at:

www.safetyandquality.gov.au/national-priorities/pbm-collaborative/national-patient-blood-management-collaborative-showcase

Communicating with patients and carers

Blood transfusion has been widely used for the treatment anaemia and haemorrhage. However, because they are biological materials, the use of blood and blood products is not without risk, and their use can lead to complications and adverse outcomes for patients. Prior to any blood and blood products transfusion, a patient and/or carer should have access to information that can inform them of; the reason why a transfusion is being recommended, the risks and benefits of transfusion and alternative treatment options.

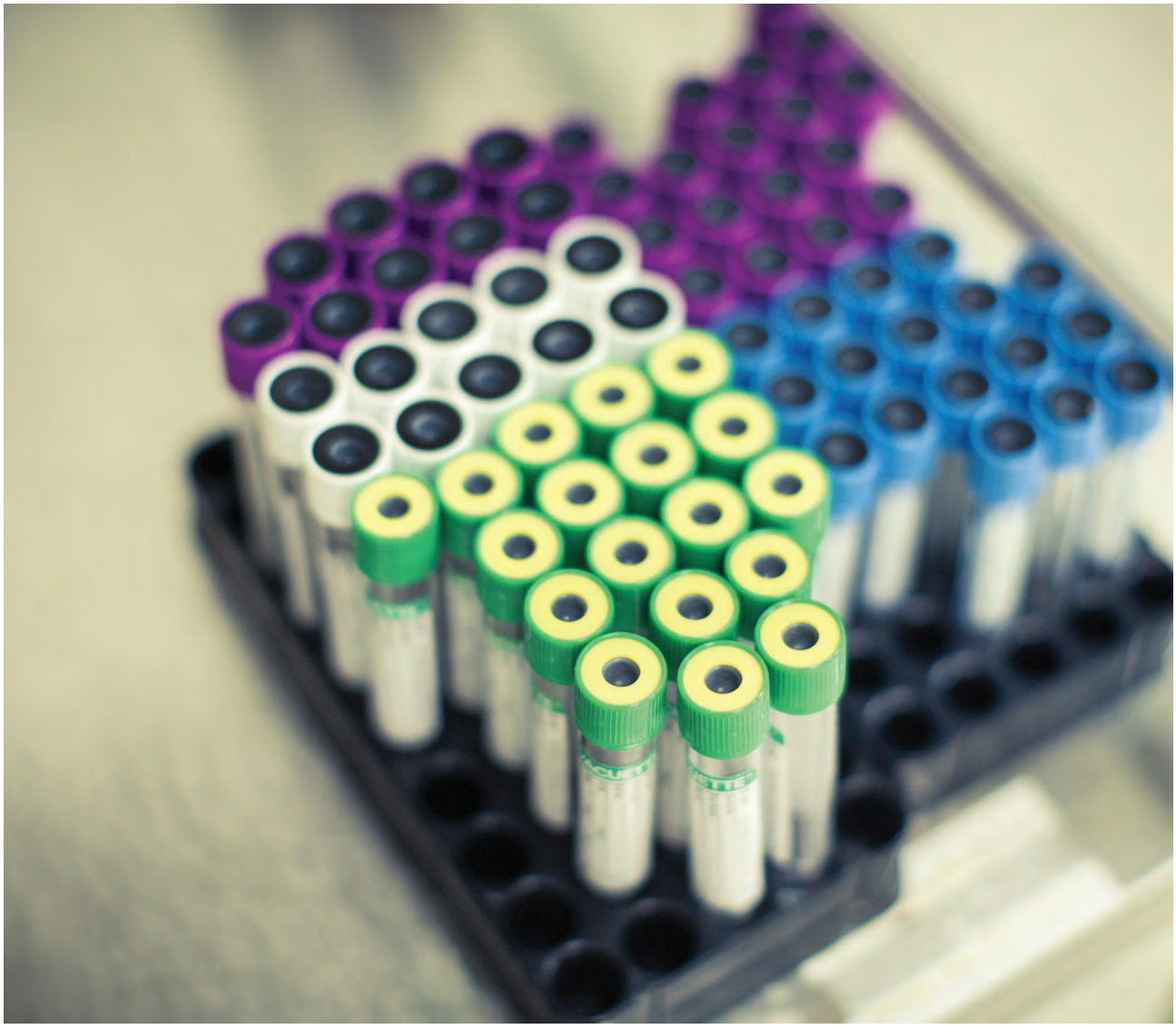
During 2016-17, consumer brochures were simplified and translated into 18 other languages relating to the following areas: "Information about having a blood transfusion"; "Iron and Iron Deficiency"; "A Guide to taking Iron Tablets"; "Intravenous (IV) iron infusions".

Further information on blood and blood products are available on the following websites:

www.sahealth.sa.gov.au/bloodorgantissue provides specific information for consumers about blood, blood components, organ and tissues, blood transfusion, iron disorders and iron therapy, organ and tissue donation.

www.sahealth.sa.gov.au/bloodsafe provides an overview of the BloodSafe clinical program and provides links for clinicians and consumers to further detailed information.

www.sahealth.sa.gov.au/bloodmanagement provides specific information for clinicians including governance, stewardship, blood fridges, transfusion practice, anaemia management and patient blood management.



Further information

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.

For more information

Safety and Quality Unit
Department for Health and Wellbeing
www.sahealth.sa.gov.au/SafetyAndQuality

Public - I1-A1

Government of South Australia

SA Health