Welcome

**Executive Director and Director of Medical Services:**
Dr Lance Le Ray

As our Directorate moves forward and expands, our approach to patient safety and quality of service needs to mature as well. We need to move beyond simply responding to each individual incident after it occurs to understanding where our risks and vulnerabilities or opportunities for improvement exist and actively seeking to make changes to improve the quality and experience of care.

At the end of 2016/17, our Directorate’s Executive Group took stock of the data we had relating to where and when adverse events were occurring and came up with 5 themes for service improvement activities. This, our very first Quality of Care report outlines the very pleasing progress we have made with each of these themes. Rather than focussing on the negatives and shortcomings, we want to showcase how our clinical services are continually looking for opportunities to improve.

**Director of Service Improvement:**
Adam Kent

The Service Improvement Unit is responsible for facilitating the Quality, Safety and Risk Management Program across Caboolture Hospital, Kilcoy Hospital and Woodford Corrections Health Centre. The Team is responsible for monitoring, reviewing and working with the clinical leaders and front-line staff to identify, implement, monitor and evaluate improvement across all clinical and business processes throughout our directorate.

In the last 18 months we have assisted the organisation in achieving both the inaugural accreditation against the National Safety and Quality in Health Service Standards including the Evaluation and Quality Improvement Program Standards for Woodford and the Organisational Wide Accreditation for Caboolture Hospital & Kilcoy Hospital alongside Redcliffe Hospital and Metro North’s Community, Indigenous Support Services.

This year’s Quality of Care Report will showcase initiatives on what we have done to improve our priority areas and in the future years will focus on the work the organisation is doing to improve the level of care our clinicians and supporting staff are inspired to do each and every day.
About the Clinical Directorate consisting of Caboolture Hospital, Kilcoy Hospital and Woodford Corrections Health Centre

Caboolture Hospital:

Caboolture Hospital is a regional hospital which provides a wide range of clinical services to Caboolture and surrounding communities. We employ more than 1,200 health professionals that together provide high-quality and tender care to more than 150,000 people each year.

Our caring team provide outstanding care across an extensive range of clinical areas including obstetrics and gynaecology, general surgery, general medicine, intensive and critical care, emergency medicine, paediatrics, and mental and allied health.

The addition of a new 32-bed adult ward and secure Gentlemen and Ladies Aging with Dignity Unit for frail and elderly patients is seeing the start of a very exciting journey to rapidly expand our services and facilities to meet the ever-increasing need of the community and an aging population.

By 2022, it is anticipated with continued investment in health care in the region, the hospital will continue to grow sharply. The expansion of the hospital capability and services will allow it to stand alongside the Princess Alexandria Hospital in size. Our vision for Caboolture 2022 is to build a better hospital with more than 100 extra beds and a significant enhancement in local Respiratory, Cardiac, Gastroenterology, Rheumatology, Geriatrics and Palliative Care services.

In the meantime, the next couple of years will be very exciting with some fabulous milestones delivered including the expansion of the Emergency Department, and completion of the new carpark and Specialist Outpatient Department.

In 2018, Caboolture Hospital will celebrate 25 years of caring for the local community.

Kilcoy Hospital

Kilcoy Hospital continues to enhance health services it offers to the local community, which is located about 94 kilometres north-west of Brisbane.

The hospital was established in 1912 and now has 21 beds with a four bed emergency service area, providing immediate emergency treatment, general medicine, allied health and management of specific conditions.

It has expanded its clinical services to include some allied health services and maternity outpatients and can provide a palliative care bed in a hospice environment.

The hospital recently welcomed the town’s first public dental service for adults. This comes after an extensive, three-year refurbishment program which has modernised the facility and seen the introduction of several new services by visiting specialists or Telehealth technology, meaning local residents have better access to high quality care closer to home, including cardiac treatment.

Patients enjoy freshly cooked meals each day and appreciate the beautiful gardens that surround the buildings, adding to its appeal. The hospital offers great views of nearby Somerset Dam and other local landmarks.

Kilcoy Hospital also has strong links with other Metro North Hospital and Health Service facilities and will transfer patients to larger facilities if their condition warrants a higher level of ongoing care.

Woodford Correctional Centre

Woodford Correctional Centre is located approximately 100kms North of Brisbane in the rural community of Woodford. The centre is specifically designed for high security male prisoners in single cell occupation. However more recently due to an increase in population there has been a requirement to pair prisoners up in single cells. It incorporates state of the art physical and security systems while maintaining a very interactive staff/prisoner management regime. Woodford
Correctional Centre, has a very large industries base with 15 workshops that manage to produce over one million dollars, worth of production in the 2014-15 financial year for the department of corrections.

Woodford Corrections Health Centre provides care for those who require medical attention. There are Clinical Nurses on duty at all times who are supported by a Visiting Medical Officer, a Nurse Practitioner, the Nurse Unit Manager and a Clinical Nurse Consultant. The Clinical Nurses supply medications twice daily generally at the same times as meals to ensure prisoners are in their accommodation units. Medications are supplied at lunchtime if ordered by the Visiting Medical Officer. Prisoners with Diabetes attend the Medical Centre where they administer their own Insulin. The Visiting Medical Officer and the Nurse Practitioner provide clinics onsite and the facility shares health services with Oral Health and Mental Health Services.

**Consumer Representation & Community Partnerships**

Health literacy means people can obtain, understand and use the health information and services they need to make appropriate health decisions, and to manage their condition for improved quality of life. We are committed to providing information and improving interactions with our patients and the community we serve which is why we are proud of our consumer engagement program and our partnerships with our community providers to ensure we are provided consumer based healthcare.

**Consumer Representation:**

We are proud to identify that we have ten (10) formal consumer representatives. We also have a very active volunteer support network. This includes the following:

- Six (6) volunteers contributing to the Heart Support programme
- Twenty-one (21) volunteers in the Hospital Auxiliary
- Thirty-four (34) St John volunteers and
- Four (4) chaplains supporting staff, patients and visitors.

**Community Representation:**

We are proud of the work we have pioneered and continue to develop with our community partners, we have a wide range of community partnerships which include:

- Caboolture Healthcare Academy
- Brisbane North Primary Healthcare Network
- Cultural Partners
- Primary Care Sector including NGO’s
- Queensland Police Service
- Queensland Ambulance Services
- Department of Communities, Child Safety & Disability Services
- University of Sunshine Coast
- University of Queensland
- Queensland University of Technology
- The Prince Charles Hospital Research Foundation
- Caboolture TAFE
- Caboolture State High School
- Saint Columban’s High School
Fast Facts:

Episodes of care provided across the Directorate:

- Admissions to hospital: 30,759
- Staffing Numbers:
  - Medical (including VMO’s) 192
  - Nursing 713
  - Operational 31
  - Managerial and Clerical 172
  - Professional and Technical 91
- Caboolture Outpatient appointments: 78,077
- Kilcoy Outpatient appointments: 311
- ED presentations: 53,270
  - QAS Arrivals: 18,591
- Births: 1,938 (averaging 5 births a day)
- Surgical operations
  - 8,007 procedures including:
    - 4,388 operations
    - 2,881 elective surgery cases
    - 1,505 emergency surgery operation
Improving Patient Safety:

The risks associated with the delivery of health care services are well recognised, and the impact of how preventable clinical incidents contribute to adverse outcomes is clearly defined in large scale studies that have been replicated across a range of international settings. In 1995, the Quality in Australian Health Care Study estimated that adverse events were associated with up to 16.6% of hospital admissions, and suggested that nearly half of those events may have been preventable.

The cost of treating patients who have experienced preventable harm and adverse events is recognised to be significant. It represents a significant loss in relation to additional treatment and intervention, and also represents wasteful, inefficient and ineffective care. In addition to the impact on patients and their families, a high rate of adverse events also contributes to workforce dissatisfaction, poor morale and distressed patients, carers and families.

The Directorate embarked on the identification of high priority areas based on clinical incident data assisted by a deep dive of our reported clinical incidents over a 3 year period and based on staff feedback from patient safety culture surveys from the last 2 years.

The analysis of incidents and feedback collected from staff identified 5 areas that the Directorate wanted to focus on improving over the succeeding 12 months to improve patient safety support systems and patient outcomes of care.

The 5 priorities areas identified for the 2017/18 Financial Year included:

1. Acute Surgical Cases with a particular focus for patients presenting out of hours
2. Acute Clinical Deterioration - early recognition and early response
3. Clinical Review processes (review of clinical outcomes)
   a. Safety and Quality Outcomes
   b. Morbidity and Mortality
4. Medication Safety
5. Clinical Communication
1. Acute surgical cases presenting out of hours

“The Department of Surgery at Caboolture Hospital is dedicated to ensuring that its patients receive high quality care that is accessible to all in a culturally sensitive environment. We aspire to deliver care in a manner which is an exemplar for quality and safety as a secondary hospital.” Dr Brian Kirkby (Director of Surgery) and Marli Millas (Surgical Nursing Director)

A key patient safety initiative was to improve right place and right time of care for acute surgical cases that present to the Caboolture Hospital after hours was identified from the review of evidence based health data.

Key strategies to improve the safety and care of these patients who present after hours were:

- Undertake a review of the Surgical Services within Caboolture Hospital to better meet the needs of the community and to ensure that robust process is in place that supports the patient from time of presentation to surgical intervention.
- Streamline communication between teams and team members regarding after hours acute surgical cases.

Surgical Patient Journey:

- The Metro North’s State-Wide Clinical Skills Development Service (CSDS) partnered with Caboolture Hospital using a wide range of improvement techniques from Human Factors, System Thinking and Safety 2 observations, recorded observations with facilitation and debriefing, simulation, education and co-design looking at the single patient handover journey of a surgical patient from the Emergency Department into the Operating Theatre and also within the Day Procedure Unit.

CSDS Findings:

- Observations:
  - Clarity and Understanding of processes and roles needed to be defined
  - Shared perspective on the patient care journey required
  - Improved coordination between departments required
- Local Perceptions:
  - Surgical rostering to be reviewed
  - Improved understanding of surgical constraints
  - Self-Awareness of work done vs work as imagined
- Local Commitments:
  - Develop an agreed referral and admission protocol between departments
  - Promote mutual respect and understanding
  - Support and enable innovative methods of quality
  - Review the Surgical rostering system
- Suggested Next Steps:
  - Continue commitment to reduce bureaucracy
  - Continue to build capability amongst the local improvement group to support the workforce
• We are continuing to improve patient flow from the Emergency Department to the Surgical Ward or to the Operating Theatre. A workshop to better understand the Surgical Patient Journey was held in April 2018 which allowed the service to identify the issues, barriers and priority areas that we need to focus on over the next 12 months to ensure that we are doing the best we can to provide better care for our patients.

**Improving Communication after hours:**

• The Medical Escalation Process after hours to an on-call surgeon has been updated and now requires communication to occur between Senior Medical Consultant to contact the Surgical Consultant on call.

• There has been a concerted effort to improve response times from the surgical service to seeing surgical patients in the emergency department. We can now see a significant improvement in the time it has taken, once a patient arrives in the emergency department and a request for a surgical consult goes in for a surgeon to see the patient.

**New Leaders commencing at Caboolture Hospital:**

Director – Dr Brian Kirkby

L to R: Angela Hand (Nurse Unit Manager – Operating Theatre, Recovery and Clinical Sterilisation Services Department), Marli Millas (Nursing Director – Surgery & ICU) & Graham Winbank (Nurse Unit Manager Day Procedures Unit)
2. Improve recognition and support for the deteriorating patient in clinical areas

It is acknowledged that patients presenting to hospital with an acute illness are at risk of becoming more acutely unwell. The following strategies are aimed at supporting these patients:

- Revised MET Call Procedures
- Revised ICU Admission Procedure
- Develop & Implement Hospitalist Model
- Implementation of an ICU Clinical Nurse Consultant Outreach Position

**Revise MET Call Procedures**

The Medical Emergency process within Caboolture Hospital is focused on providing a rapid response to deteriorating patients within all areas of the facility. This response is made up of a team of medical, nursing and operational support officer and staff within clinical areas.

There are several process documents that outlined the formal process for how this rapid response system operates within facilities. As part of the Safety and Quality Plan for 2017 these documents were revised to ensure clearer roles and responsibilities in identifying deterioration and responding to that deterioration.

Key outcomes from this review include the following:

- All documents (9) have been peer reviewed and endorsed by the Recognising and Responding to Clinical Deterioration Committee.
- Medical Emergency Response (Rapid Response Team) are delegated to respond to activations of the system. A key outcome of this initiative was the development and implementation of the following flowchart identifying key accountabilities of the medical emergency response process.
Another key outcome was the review and re-implementation of an escalation process to support staff in escalating concerns related to clinical management issues of patients that may affect their safety. The following flowchart was also developed as a clinical support tool for staff when escalating concerns.
Standard 9 Recognising and Responding to Clinical Deterioration in Acute Health Care

Escalation of Clinical Management Issues – Caboolture Hospital

CLINICAL INCIDENT IDENTIFIED

INCIDENT MANAGED AT WARD/UNIT LEVEL

CLINICIAN IDENTIFIES A CLINICAL MANAGEMENT ISSUE

Alert Senior Clinician / Line Manager / Shift Co-ordinator
• Use ISOBAR to communicate issue

Senior Clinician / Line Manager / Shift Co-ordinator investigates clinical management issue

Is the clinical management issue able to be resolved?

YES

Implement and document patient care strategies

Patient safety maintained

NO

INCIDENT ESCALATED TO REGISTRAR

• Clinician contacts patient’s Registrar or ON-call Registrar
• Notify in hours the Nurse Unit Manager (NUM) and after hours the Hospital Coordinator of clinical management issue.
• Use ISOBAR to communicate issue

Clinical management issue resolved by Registrar (on-call)

YES

Implement and document patient care strategies

Patient safety maintained

NO

INCIDENT ESCALATED TO CONSULTANT

Senior Clinician / Line Manager / Shift Coordinator / Hospital Coordinator to contact the patient’s Consultant / On-call Consultant
• Use ISOBAR to communicate issue

Clinical management issue resolved by Consultant/On call Consultant?

YES

Implement and document patient care strategies

Patient safety maintained

NO

INCIDENT ESCALATED TO EXECUTIVE TEAM

• Notify Executive Team member on-call regarding the clinical incident and identify the status of the patient
• Use ISOBAR to communicate issue

Executive Team member implements strategies to resolve clinical management issue

INCIDENT MANAGED
Revised ICU Admission Procedure

Acutely unwell patients who required escalation in supportive care therapies such as intensive care where only able to be managed for a limited time as there was no dedicated Intensive Care service available at Caboolture Hospital. These patients required inter-hospital transfer to continue supportive therapies at other facilities increasing risk factors for these patients.

In late 2015 an Intensive Care Service was established at Caboolture Hospital. The establishment of this service further supported the deteriorating patient within Caboolture Hospital.

A key outcome of establishing this service is that there is timely and appropriate support provided to the deteriorating patient in the right area. The following graphs demonstrate how this new service has positively supported the medical emergency response system.

![Percent of True MET Calls Requiring ICU Transfer](chart1)

![Percent of True MET Calls Requiring Transfer to CCU](chart2)
Develop & Implement Hospitalist Model

Due to fatigue levels for the ICU Consultants that manage the ICU’s at Caboolture and Redcliffe Hospitals, the ICU at Caboolture was under threat of not being able to be supported by the Medical model moving forward. The hospital needed to take action to ensure the most critically unwell patients at the hospital were able to be cared for locally, rather than require transfer to Redcliffe Hospital or the Royal Brisbane & Women’s Hospital.

Caboolture Hospital implemented a temporary hospitalist approach to support continuity of care for patients and to promote patient safety. This approach sees a physician led team (ED and Anaesthetic Consultants) accept care for new patients coming into the hospital and manages their care for their hospital stay. This team is further supported by other acute care teams (ICU) and medical specialists.

ICU Fast Facts:
There were 314 Caboolture ICU patients admitted for FY 2017
- 10.51% (n=33) were transferred to a MN facility
- 7.96% (n=25) were transferred to another ICU
- 81.53% (n=256) critically unwell patients were able to be cared for locally

Queensland Bedside Audit:
Each October the Clinical Directorate participates in the State-Wide Queensland Bedside Audit to determine performance against a number of indicators to ensure we are assessing our performance against minimum care standards. This includes our performance against those indicators that evaluate our recognition and response to clinical deterioration whilst patients are being cared for here at the hospital.

Our results from 2016 to 2017 indicate improved performance across most indicators at Caboolture Hospital in the last 12 months including higher performance when comparing our results with MNHHS and the state-wide results. The following shows the improved performance over the last 12 months and how we compare:

Recognising and Responding to Clinical Deterioration Queensland Bedside Audit 2017

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Caboolture 2016</th>
<th>Caboolture 2017</th>
<th>MNHHS 2017</th>
<th>State-wide 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients who had an observation chart for recording core vital signs</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>% of patients who had an observation chart where a complete set of core observations was recorded as specified in the monitoring plan</td>
<td>79</td>
<td>99</td>
<td>88</td>
<td>88</td>
</tr>
<tr>
<td>% of patients who had a Q-ADDS chart where a complete set of observations was recorded as specified in the monitoring plan</td>
<td>80</td>
<td>85</td>
<td>85</td>
<td>81</td>
</tr>
<tr>
<td>% of patients who had a CEWT chart where a complete set of observations was recorded as specified in the monitoring plan</td>
<td>88</td>
<td>100</td>
<td>58</td>
<td>76</td>
</tr>
<tr>
<td>% of patients who had all recorded observations plotted and trended</td>
<td>78</td>
<td>84</td>
<td>85</td>
<td>80</td>
</tr>
<tr>
<td>% of patients who had an observation chart with a scoring system where a total score was recorded for the last set of observations</td>
<td>96</td>
<td>93</td>
<td>96</td>
<td>93</td>
</tr>
<tr>
<td>% of patients who had an observation chart with a scoring system where the total score for the last set of observations was added up correctly</td>
<td>97</td>
<td>93</td>
<td>95</td>
<td>95</td>
</tr>
<tr>
<td>% of patients who reported being aware of the Ryan’s Rule process</td>
<td>69</td>
<td>76</td>
<td>69</td>
<td>61</td>
</tr>
</tbody>
</table>
Team:
Recognising and Responding to Clinical Deterioration Committee

L to R Back Row: Dr Anand Choudhary (Deputy Director Medical Services), Dr Danielle Spratt (Staff Specialist Emergency Department), Michelle Weldon (Clinical Nurse Consultant CCU), Rachel Bailey (Clinical Nurse Consultant ICU Outreach), Stephen Brand (Clinical Nurse Consultant Service Improvement Unit), Elizabeth Cooper (Nurse Unit Manager ICU), Dr Ramsy Dsouza (Chair RRCD Committee & CRICU Intensivist) & Dr Lynnette Knowles (Medical Administration Registrar)

L to R Front Row: Justine Lang (Acting Service Development Coordinator Mental Health), Ronal Kumar (Acting Nurse Unit Manager Medical Ward 4A), Colleen Herrmann (Nurse Unit Manager Surgical Ward 2A) & Michelle Hutch (Nurse Unit Manager Paediatrics)

Intensive Care Unit:

L to R: Luke Tung (Clinical Nurse Consultant), Dr Arif Shaikh (Director of ICU), Pat Andre (Clinical Nurse), Melissa Petty (Registered Nurse) & Dr Jonathan Alcock (Resident Medical Officer)
3. Review of Clinical Processes (Clinical Outcomes with regards to Morbidity and Mortality)

“It is a great privilege to Chair the Provision of Care Committee. This Committee demonstrates true multidisciplinary team working; their leadership, drive and commitment in providing safe, high quality care where they are continually striving for effective patient outcomes is commendable.

Adherence to the Provision of Care Standard by our teams across our services ensures our patients/consumers receive high quality care throughout the whole of their journey with us and it is managed with the comfort and dignity they deserve. Our patients families and their carers are just as important to us and it is essential that they are included and supported throughout their loved ones care continuum.”

Julie Lahey – Director of Nursing and Midwifery

In partnership with Metro North HHS, the Caboolture Hospital’s Provision of Care Committee commissioned an end of life care working party to review the deceased and dying patient processes across the directorate to ensure that the process is clearly documented, well known and well followed. The review identified that there were inconsistencies of practice with other MNHHS facilities and international best practice with regards to caring for dying and deceased patients and their families.

Recommendations that came out of the review that have been implemented include:

- Develop a Deceased Patient (Adult and Child) Procedure
- Develop a Deceased Baby including Miscarriage, Stillbirth, Neonatal & Post Neonatal Procedure
- Develop and Death Review Procedure including a detailed death review form
- Develop a Morbidity and Mortality Meetings Procedure based on international best practice
- Develop a Care of Dying Patient Procedure in partnership with the Palliative Care services across MNHHS

All procedures have been developed, were endorsed by the three peak clinical committees across the Directorate (Medical Leaders Group, Caboolture Hospital Nursing Leaders & Allied Health Operational Management Group) and the procedures were also presented at the Medical Grand Rounds in November 2017.

Following the implementation of the procedures, work continues to ensure consistency across each of the clinical disciplines to meet the additional requirements.

Awards or Recognition:

- The Provision of Care Committee, were the winners of the Caring Together Excellence Award for the Category of Values in Action.
L to R: Julie Lahey (Chair Provision of Care Committee & Director of Nursing and Midwifery), Megan Mowbray (Patient Safety Officer) & Associate Professor Dr Cliff Pollard AM (MNHHS Board Member)
4. Improvement medication safety processes across the directorate

“The Medication Management Committee for the Directorate is a team of dedicated clinicians who provide oversight and clinical leadership in all matters of medication management, including addressing risks and issues as they arise, continually evaluating what we do to see if we can do better, implementation of improvement initiatives to trial better processes to improve care for our patients and achieving the requirements of the National Safety and Quality Standard on Medication Safety” – Dr Anand Choudhary – Chair of the Medication Management Committee

Medication therapy is one of the most frequent treatment options provided to patients within the acute care setting. This can be achieved by oral administration through to intravenous methods. Medication Safety has always been a priority area for patient safety across Caboolture and Kilcoy Hospitals.

Fast Facts:

- 11% Adverse Drug Events Originate from Transcribing/Communication error
- 50% Adverse Drug Events Originate from Prescribing error
- 30% Adverse Drug Events Originate from Administration Error
- 4% Adverse Drug Events Originate from Dispensing or failure to review

The Director of Pharmacy presented a deep dive of medication safety at the Directorate’s Monthly Performance Review and identified a number of organisational achievements over the past 12 months with regards to improvement medication management including:

- Organisational Improvements:
  - Key appointments within Pharmacy Department
  - Enhancements in quality and financial reporting across the Directorate
- Woodford Improvements:
  - Enhanced pharmacy service focus (supply and clinical)
  - Incident reporting
  - Procedural framework
- Kilcoy Improvements:
  - Access controls
  - Enhanced pharmacy service focus (supply and clinical)
  - Multi-disciplinary medication (sub)committee performance

Additional Initiatives:

1. Medication Audit Nurse Educators:

- From the review of practice and reported incidents by staff, the Nurse Educators collaborated to undertake a review of medication practice within their areas of responsibility. The review involved the Adult Patient clinical areas of Ward 2A (Surgical), Ward 3A and 4A (Medical) and involved having the Nurse Educators present at the point of care for Monitoring and Coaching during medication administration rounds
• Findings included:
  - Several prescribing errors noted during the audit ranging from:
    • Medications ordered despite allergies
    • Illegible and incomplete orders
    • Abbreviations not meeting the prescribing standards
    • Very few medication orders having documented indications

• Further initiatives to be undertaken:
  - For a full week the three wards, 2A, 3A and 4A nursing staff will be requested to photocopy medication charts that have errors and place them in a supplied box. At the end of the week the boxes will be collected and the results will be tabulated to demonstrate if there are common errors being made.
  - Education and feedback will be given regarding these results with the aim being to bring about a change of culture regarding medication safety.

2. **ED Medication Review:**

This review focussed on the Caboolture Emergency Department (ED) ensuring a continuous cycle of improved medication safety by utilising a variety of quality improvement activities that can enhance clinical documentation, medication management and patient centred care.

• The purpose of this quality initiative was to improve medication safety in the ED by increasing compliance with the 6 rights of medication safety
  - Right Patient
  - Right Drug
  - Right Dose
  - Right Route
  - Right Time
  - Right to Refuse to Administer

Results of the pre-quality initiative audit:
• Overall compliance with the 6 rights of safe medication administration equalled 49.1%
  - 71.4% compliance on single check medications
  - 42.5% for double check medications

• Recommendations for improvement included partnering with the pharmacy department to educate staff focussing on 3 areas:
  - Staff going to the bedside
  - Witnessing the preparation of medications
  - Checking infusion start and rate

Results of the post-quality initiative audit:
• Overall compliance with the 6 rights of safe medication administration equalled 90.0%
  - 88.2% compliance on single check medications
  - 90.7% for double check medications
3. **HALLT Ward 4A:**

- Ward 4A implemented a rapid improvement surrounding HALLT (Hungry, Angry, Late Lonely or Tired) human factors which could lead to clinical incidents, particularly medication administration error.

- The improvement implemented the following aim for the initiative:
  - Educate staff on the impact their emotion/status potentially has on patient safety
  - Increase self-awareness for individuals at increased risk
  - Increase team awareness of staff at risk
  - Discuss team strategies to deal with the HALLT criteria
  - Provide increased support for individuals and among colleagues
  - Reduce the number of humanistic contributors to incidents in 4A
  - Reduce the number of incidents in 4A, and prevent the 'second victim'

- **Key Changes Implemented included:**
  - Visual Prompts - Posters placed at key points in the ward
  - Inclusion in the Scrum process - Handover routine – start of shift scrum includes asking everyone to check in on staff to see if they are affected by HALLT criteria
  - Staff Education - Ward staff received in-service to provide background of the change, and explain the acronym

- **Preliminary Results:**
  - Incidents reduction of 31.7% per month since the initiative implemented. Including a reduction of 25.3% relating to human error. Incidents relating to communication error or documentation have also reduced by 22.9%
  - Staff feelings about HALLT:
    - “It's really good – I have used it when I have felt the need to calm down”
    - “I haven’t really used it to address things with other staff, but I just take the time when I need it, letting staff know I will be off the ward for 5 minutes”
    - “I am more aware about my emotions, particularly before giving meds”
Awards or Recognition:

- HALLT initiative was voted by peers at the Health Round Table Patient Safety Improvement Conference as the most Outstanding Innovation to Improving Patient Safety

- Timothy Dunn, Director of Pharmacy was voted as the winner of the Caring Together Excellence Award for the Category of Leadership
5. Clinical Communication (Clinical Handover)

The Clinical Handover committee commenced as a way to ensure governance over the National Safety & Quality in Healthcare Standard Clinical Handover. However, over the last 12 months the committee has merged with the patient identification and procedure matching committee to look at ways we can better communicate clinical information throughout the patient journey, no matter what part of the hospital you’re in.

Verbal communication between clinicians account for the major part of the information flow in healthcare (about 50%), and by having ineffective communication or information that is not understood by the all parties increases the risk of adverse events. This is why, we at the hospital are continually striving to improve our clinical communication processes to ensure our patients are as safe as possible at all times.”

Dr Anand Choudhary – Chair - Communicating for Patient Safety Committee

Clinical Handover (CH) is the communication process that enables transfer of professional accountability and responsibility from 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”. This includes;

- Ward to ward handover
- Staff to staff handover
- Facility to facility handover
- And all other interactions with the patient

Improvement Initiatives:

- An interactive, experiential communication learning program has been developed based on the principle of Communication, Respect & Accountability = Safe Health Care (CRASH)

The 4hr CRASH program has been integrated into the core Orientation program as well as a scheduled monthly program for existing staff.
All staff are required to attend the CRASH program, with 450 having participated to date. The objectives of the program are

- Create an awareness of the significant impacts of communication in the delivery of healthcare services and the individual accountability related to communication
- Provide an opportunity to experience and recognise when communication is and isn’t working and reflect on how to apply this in the workplace
- To experience 4 core communication tools that can be used proactively and reactively to ensure productive communication

The delivery model sees mixed interdisciplinary groups that have included operational, nursing, admin, allied health and senior medical officers participating together in small team activities.

Regular feedback is “This is really good, everyone should have to do this program”

Elements of the program are delivered separately as components of other activities such as CN Development days and junior doctor lunchtime education sessions.

- The Emergency Department had completed a research article on “optimising the emergency to ward handover process: A mixed methods study” and has been published in the Australasian Emergency Nursing Journal.
  - Key findings of the review included:
    - To deliver an optimal nursing handover from the emergency department to various wards handovers should be structured and provide standardised content.
    - The form developed at Caboolture has received positive reception and use of this form provides evidence that a structured handover process can ensure standardisation of emergency department to ward nursing handovers.

- Clinical Handover: “Definition, Performance and Improvement Required” was presented at the November 2017 Staff forum
• Posters were developed “Don’t drop the ball at handover” and displayed in all clinical areas across the hospital – using local staff in the posters to show all staff and consumers that this is important aspect of healthcare at a local level.
2018 / 2019 Safety and Quality Plan:

“High quality health care should be as safe and effective as possible, with patients treated with compassion, dignity and respect. Quality means care that is personal to each individual” Lord Dazi, 2008.

The 2018/19 Safety and Quality Plan is currently in development to identify the focus areas of this coming years plan. The Service Improvement Unit is currently completing interviews and surveys with multiple stakeholders including:

- Executive
- Clinical Leaders
- Point of Care Clinicians
- Clinical Support Staff
- Non-Clinical Staff
- Patients/Carers/Relatives
- Consumer Network

The aim of the survey is to engage with everyone from all walks of life to identify what high quality health care means and looks like to the individual, including how it can be measured and to highlight what needs improving across the directorate based on their thoughts and values that is consistent with international best practice and supported by organisational safety and quality indicator performance.

For more information on the 2018/19 Safety and Quality Plan priority indicators please contact the Service Improvement Unit on 5433 8608 or email the team on CABH-SIU@health.qld.gov.au