

QUALITY ACCOUNTS

2013/2014

QUALITY & IMPROVEMENT
DIRECTORATE



Northland District Health Board Quality Accounts 2013

Quality is important to us all and we are making steady progress against each of our nominated priorities. We have a growing focus and commitment within the organisation for continuous improvement, striving to become a truly patient-centered organisation of excellence



Dr Nick Chamberlain
Chief Executive



Margareth Broodkorn
Director of Nursing & Midwifery



Dr Mike Roberts
Chief Medical Officer

What are Quality Accounts?

Quality Accounts were introduced into the UK National Health Service (NHS) in 2009 and following testing in several NHS Trusts, became a reporting requirement for all trusts within the NHS during 2010. The aim was to demonstrate the importance of quality of care as being a core business for the NHS by placing the reporting of quality on an equal footing with financial reporting.

The Health Quality & Safety Commission New Zealand (HQSCNZ) identified in their Statement of Intent 2011-14 their priority to identify indicators of quality and safety in health, with the aim to standardise and streamline quality reporting across the New Zealand healthcare sector.

Purpose

The principal purpose of the Quality Accounts is to encourage Boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer and encourage them to engage in a wider process of continuous quality improvement.

Definition

Quality Accounts are annual reports from health and disability service providers about the quality of the services provided, and how each provider is progressing in terms of continuous quality improvement, the consumer experience and health outcomes.

Quality Accounts provide a mechanism through which health and disability service providers are able to transparently share their successes, learnings and future improvements with the public and the wider sector.

A broad range of clinicians (Medical, Nursing, Allied Health and Management) were engaged to scope and determine the initial six Northland DHB Quality Accounts. Priority has been given to areas that will help to improve the quality of care and the service provided to patients.

The six Northland DHB Quality Accounts are:

- Reducing harm from falls
- Improving the use of the surgical checklist
- Reducing central line infections
- Increasing medicine reconciliation
- Improving hand hygiene
- Preventing pressure areas.

QUALITY & IMPROVEMENT
DIRECTORATE



ZERO HARM FROM FALLS

FALLS ARE COSTLY

A fall can be life changing for an older person, impacting on their independence and wellbeing, with implications for their family or whanau and significant others.

The cost of each patient fall that causes a minor injury is estimated at \$600. A hip fracture causing a three week stay in hospital is estimated to cost \$47,000 per patient and a hip fracture with complications and discharge to an aged residential care facility costs \$135,000 per patient.

The direct cost of patient falls in hospital for 2010 - 2011 was between \$3 million dollars and \$5 million dollars in New Zealand. However, figures from international studies and analysis of New Zealand data suggest the total resources used by falls are 2 - 2.5 times higher than the direct costs, which could mean the true cost could have been around \$6-12 million dollars per annum.

In 2011, 77 patients were harmed when they fell and Northland DHB was reporting approximately 12 falls each month. Whangarei Hospital's Ward 15 decided to do something about the falls and is making a positive difference.

"We are now working closely with the 'First Do No Harm', regional falls programme. All Northland DHB inpatient wards now have Falls Nurse Champions who lead the collection of data to analyse the number of falls per month. This data is then reviewed to understand better where in the ward the fall occurred, at what time of day and what activity the patient was involved in when they fell. Based on this data they are testing changes to their model of care or working environment to prevent further falls from occurring. Each patient that is assessed as a high risk for a fall has an individualised management plan to help prevent falls occurring", offered Associate Director of Nursing, Sheryll Beveridge.

"Nurses gave clear instructions when patients went to stand. The nurse took time with mum to help her stand, encouraging her to take her time and walking with her to the toilet", said a Patients daughter.

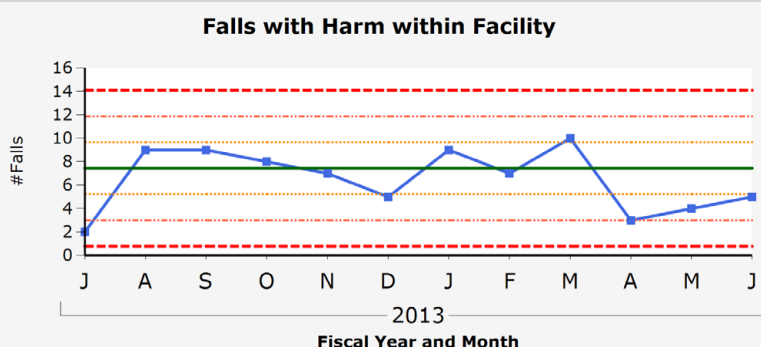


LEFT: Trying on non-slip red socks, Mr Abbs a patient from Ward 15 and Student nurse Jason Wordsworth.
RIGHT: Falls Project Leaders Denise Watene Clinical Nurse Manager; Lisa Cutts Associate Clinical Nurse Manager; (Not in photo) Dr Christopher Hutchinson Consultant Geriatrician, Clinical Lead

Target - no harm from falls whilst in an NDHB Hospital

Showhart Chart

System performance charts have a centre line as well as an upper and lower limit. These charts help us to learn about variation and to evaluate the impact of changes.



INCREASING THE USE OF THE SURGICAL CHECKLIST



Kia Tupato - Take Care! Taihoa - Take Time Out!

Gary Sakey Associate Clinical Nurse Manager - Perioperative Services

In June 2008 the Safe Surgery Saves Lives Initiative released the World Health Organisation Surgical Safety Checklist globally. Over the last two years more than 3,900 hospitals representing more than 122 countries have registered as Safe Surgery Saves Lives Participating Hospitals signifying their intent to introduce the World Health Organisation's Surgical Safety Checklist in their operating theatres.

"Northland DHB introduced the surgical checklist in 2010 with the key intent to improve patient safety in the operating theatre. The theatre team is currently revising the operative pathway that includes the Timeout Checklist. The aim is to have a more concise and user friendly checklist", said Marilyn Andela, Nurse Manager, Perioperative Services.

Target - 90% Compliance



Right Patient? Right Procedure? Right Site? Right Preparation? RIGHT RESULT!

CENTRAL-LINE ASSOCIATED BACTERAEMIA (CLAB)

PROBLEM ANALYSIS

Central venous lines are common in Intensive Care Units (ICU). Nationally there are approximately 19,000 ICU admissions each year. With these vulnerable patients, there is a serious risk of central line infection, and with it an associated mortality of 4 - 20%. Furthermore, the cost of each CLAB has been estimated to be between \$NZ 20,000 and \$54,000.

At Northland DHB we had:

- Potential for ongoing morbidity and mortality from CLAB, even though we had one of the lowest CLAB rates in the country
- No standardised process for insertion and maintenance and surveillance of Central Venous Lines
- A good clinical teaching process in reducing CLAB, but there was ongoing potential for rates to increase - Dr Sven Karman, ICU Consultant and Clinical Leader for the CLAB Project.

"We have been working with the national programme since July 2012 and to 30 June 2013 there have been NO central line infections. Insertion practice documentation and equipment has been standardised. The ICU team has used an improvement model working with PDSA Cycles (plan, do, study and act) to ensure our new processes are well embedded", said Sarah Pickery, Clinical Nurse Manager ICU.

"The CLAB project has raised awareness within the unit for strict hand hygiene when dealing with central lines, best practice is promoted and staff are now seeing the importance of the 'packages of care'. I am pleased with the change in culture and the hard work has paid off", explained Nina Gresswell, Associate Clinical Nurse Manager ICU.

"CLAB Prevention is well established in Whangarei ICU and is gradually being rolled out to other clinical areas to ensure we all actively reduce the risk of infection in all patients with a central line", said Sheryll Beveridge, Associate Director of Nursing.



Clinical Lead Dr Sven Karman &
Project Lead Nurse Manager Sarah Pickery

Target - No Infections

**Days since Last
Central Venous Line
Infection**

367

(As at July 2013)

MEDICINE RECONCILIATION

The latest Serious and Sentinel Events report showed that 18 serious medication errors were reported in New Zealand hospitals during the 2011/2012 period. This is just the tip of the iceberg - estimates vary, but somewhere between 2 and 13 % of patients admitted to hospital are estimated to have an adverse drug event of some description.

Some of these patients will be harmed as a result, or have to spend extra time in hospital. This is not only an unnecessary inconvenience to patients and their families, but it also increases costs to the health system (HQSCNZ 2013).

Medication errors and patient harm can result from inaccurate or incomplete medication histories that are subsequently used to generate medication regimens for hospitalised patients. Discrepancies may exist among what is documented in the patient's medical record, outpatient's clinic or office records, prescription bottles, outpatient pharmacy records and what medications the patient is actually taking.

Often patients are taking medications for which there is no documentation, some patients not taking their medications and there are differences in the dosage of medication being used. Without appropriate verification of the actual medication regimen (reconciliation) and failure to detect drug-related problems, missed diagnoses or errors in patient admission drug charts can occur.

"Medicine reconciliation is a routine service in some wards at Northland DHB. In these wards a pharmacist will collect medication-related information for newly admitted patients, and will compare the prescriptions on the inpatient medication chart to the medications the patient has been using before their hospital admission", said Helen Dunn, Pharmacy Manager.

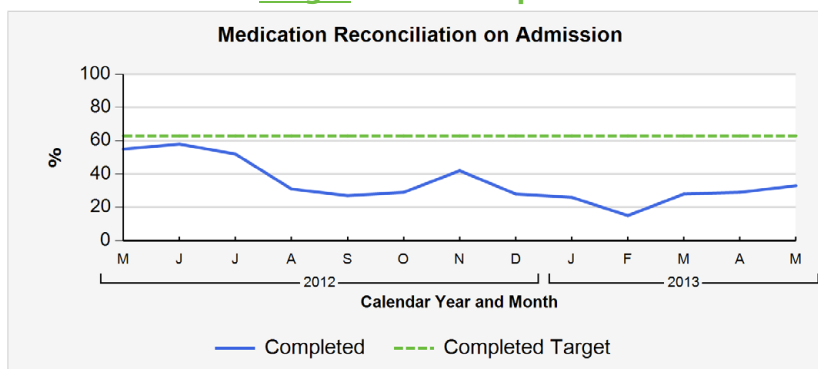
"Doctors will then look at the differences and decide what should continue to be prescribed. As the pharmacy team currently leads the initiation of the medicine reconciliation process, a reduction in pharmacy staffing levels can affect the number of medicine reconciliations Northland DHB can perform. Northland DHB is continuing to work on strategies to improve the delivery of the medicine reconciliation service."



Left: Pharmacist Kay Lengyel & Ward 14 patient Mrs Kirkham - RIGHT: Pharmacist Haruna Makita

"Its great that staff have time to talk to me about my medication. It makes all the difference", Mrs Kirkham said.

Target - 63% Completed



HAND HYGIENE

Patients health and welfare are put at “serious risk” as a result of poor hygiene practice, lets do it right!

The Hand Hygiene New Zealand project (HHNZ) was introduced at Northland DHB as part of the National Quality Improvement Programme in 2009. The Ministry of Health, in its 2006 publication ‘Scoping Priorities for Quality Improvement in the Health and Disability sector’ set out a national programme for Infection Prevention and Control (IPC). Included in this programme and ‘first out of the blocks’ was Hand Hygiene.

This was in response to the World Health Organisation (WHO) statement ***‘the most simple and effective means of avoiding infections is good hand hygiene and failure to comply is the leading cause of healthcare associated infections. Poor hand hygiene contributes to the spread of multi-resistant organisms and is a significant contributor to infection outbreaks’.***

The IPC team rolled out this programme in 2009. Currently five areas are audited three times a year with 350 moments observed in each. These high risk area audit results are reported nationally with audit results available on the HQSCNZ website. In addition to the national audited areas, the IPC team audits all other areas in the hospitals and report these results locally. An organisational project, with a focus on further improving hand hygiene started at Northland DHB in August 2013.



Dr Usha Shan - General Surgeon & Midwife Shona Kaio

‘The Simple habit of washing hands between every patient is not only good personal hygiene but it protects patients’. - Dr Usha Shan.



Target - 90%

Hand Hygiene Compliance

68.1%

**As at
Calendar Year 2013
Quarter 2**

PREVENTING PRESSURE AREAS WHILST IN HOSPITAL

Thousands of New Zealanders have experienced a pressure injury of some degree in recent years on their hips, heels, backs, or elbows. At least eight patients have died as a result. Good nursing care is one key to preventing them. (Nursing Review 2013).

Pressure injuries are a major cause of preventable harm for healthcare services and develop most commonly over bony prominences as a result of sustained pressure or pressure in combination with shear. Injury sustained is classified into four stages, categories or grades whereby (1) is the least severe with a persistently reddened area of skin and (4) represents full thickness tissue destruction.

Patients can develop a pressure area for a number of reasons and include; age, lack of mobility, poor diet, moisture, friction and shearing, neurological and other physical problems, even from wrinkled bed sheets, sitting on hard chairs and also if they have had pressure ulcers in the past.

The **First Do No Harm**, Pressure Injuries Collaborative has seen teams from across the northern region district health boards and residential aged care facilities engaged to raise the profile and change care practices to reduce the incidence of patients or residents developing pressure injuries.

Ward 4 at Whangarei Hospital is leading the way in reducing pressure areas development whilst in hospital. Some of the things they have implemented are:

- **Identifying patients who are at risk and using alerts so other staff are aware**
- **Doing more in-depth risk assessment and implementing an individualised plan of care**
- **Making sure all staff are educated, as well as the patient and their whanau/family.**

“The Pressure Injury Prevention interventions of care are now being implemented across all inpatient wards led by the areas delegated pressure injury prevention nurse champion. Staff have really engaged with this process”, offered Associate Director of Nursing, Sheryll Beveridge.



Project lead for pressure area project, Associate Clinical Nurse Manager Sharon Kerwin and Clinical lead, Clinical Nurse Manager Phillipa Monteith with patients and staff in Ward 4.

Target - no pressure injuries whilst in an NDHB Hospital

