



# Safety and Quality

## Newsletter

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### A Message from the Executive Director

In support of the theme for *World Patient Safety Day 2021*, this newsletter showcases many of the important initiatives being undertaken across the WA health system which focus on '**Safe maternal and newborn care**'.

Increasing access to and utilisation of health care services is important in improving maternal and child health outcomes, however the safety and quality of the care is equally or even more important.

Advances in technology, such as remote monitoring of patients (pg. 3) and sophisticated data analytics (pg. 4) provide us with exciting opportunities to further improve patient care and inform quality improvement.

Our staff continue to be our greatest asset and I commend Health Service Providers for instigating programs which recognise staff who are committed to health and safety improvements (pg. 6) as well as a new program facilitated by the Public Sector Commission (pg. 7) to nurture a safe working culture.

There are numerous opportunities for all staff and consumers to contribute to improvements across our system through participating in policy consultation and attending professional development events. We have highlighted some of these opportunities which are occurring over the next couple of months.

As we contemplate our 'new normal' in health care, there is no better time to reflect upon, embrace and develop innovative solutions to address the challenges faced by our system. I encourage you to get involved!

**Dr Audrey Koay**  
Executive Director  
Patient Safety and Clinical Quality



# World Patient Safety Day

## 17th September 2021

The theme for World Patient Safety Day 2021 is “**Safe maternal and newborn care**”. This theme was selected due to the significant burden of risks and harm women and newborns are exposed to when receiving unsafe care during childbirth.

World Patient Safety Day was established in 2019, to enhance global understanding of patient safety, increase public engagement in health care safety and promote global actions to prevent and reduce avoidable harm in health care. The Day is firmly grounded in the fundamental principle of medicine – first do no harm!



## Safe Maternal and Newborn Care – a panel discussion

In WA, to mark World Patient Safety Day 2021, and the theme of safe maternal and newborn care, Health Consumers' Council is hosting an interactive Q&A panel discussion.

In partnership with the Australian Health Practitioner Regulation Agency (AHPRA) and Women's and Newborns Health Network, the session will explore numerous topics such as Aboriginal women's experiences of childbirth, the impact of COVID on birthing women, why feedback is important and how it changes things, and how to give feedback.

Join us on **Friday 17 September 2021**  
10:30am-12:00pm Register [here](#)

The poster features a light green background. On the left, there are logos for Health Consumers' Council (a colorful bar chart) and World Patient Safety Day 17 September (a blue icon of two people). Below these is the text "In partnership with AHPRA and Women's and Newborns Health Network". The main title "Safe maternal and newborn care" is in large blue font, followed by "A World Patient Safety Day 2021 panel discussion" and the slogan "Act now for safe and respectful childbirth!". On the right, a circular photograph shows a woman in a pink shirt holding a baby in a striped shirt. The photo is framed by a stylized orange and yellow graphic.

# Safe Maternal and Newborn Care

## What's New?

### New Digital Technology to Support Regional Mums

#### WACHS Rolls Out state of the Art Foetal Monitoring System

The WA Country Health Service is set to improve the patient experience for thousands of rural and regional expectant mums every year with the [K2 Infant Guardian System](#) being rolled out across its maternity sites across 2021 and 2022.



Expectant mum Latoya with Midwives Charlene and Sophie

The benefits include:

- improved patient involvement in the management of mothers' and their babies' care with greater transparency of data;
- real-time, clinical data can be reviewed remotely by treating clinicians;
- greater privacy and fewer intrusions in the birth suite during labour with foetal heart pattern also able to be safely monitored remotely;
- the potential for a more efficient discharge process with data being readily available and remotely accessible; and
- specialist support can be provided to smaller maternity sites remotely and in real-time.

### Safer Maternal Patient Care Reinforced by Policy

#### Policy Update

The Patient Safety Surveillance Unit has updated the *Cardiotocography (CTG) Monitoring Policy* (MP0076/18) and *Standard* following a review with input from Midwifery and Obstetric stakeholders.

The revised Policy, effective from 16 June 2021, has a stronger emphasis on the CTG purpose being related to high risk pregnancy, details of ongoing clinical audit requirements and updated supporting clinical resources.

The amended CTG Policy is available [here](#).

#### Clinical Care Standard

Australian Commission on Safety and Quality in Health Care's *Third and Fourth Degree Perineal Tears Clinical Care Standard* was developed in response to a recommendation from the Second Australian Atlas of HealthCare Variation.

This Standard supports the provision of high-quality, evidence based care and reducing unwarranted clinical variation in perineal tears, and managing them appropriately when they do occur. The Standard is available [here](#)

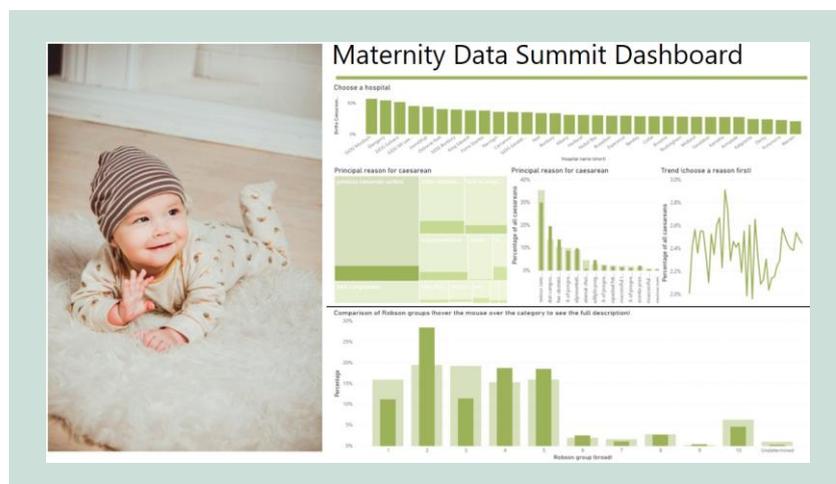
# Maternity Data Summit Dashboard

In 2020 the Healthcare Quality Intelligence Unit (HQIU) team created a PowerBI Deep Dive dashboard to bring together and review maternity data with the goal to improve the quality of patient care. This was a collaboration between the Women & Newborn Health Network (WNH), the State-wide Obstetric Support Unit (SOSU) and the HQIU team.

This dashboard showcases different aspects of the available maternity data and has provided a valuable tool to breakdown the data in a number of ways.

1. **Demographic** features for patients, including Age, BMI, Mum's smoking status, a Post-code map and ethnicity breakdown for your maternity unit. You can use this to benchmark against all the other units in the state.
2. **Caesarean Section Rates:** showing the overall rate and two separate rates for scheduled and unscheduled C-sections. Reasons for Caesarean Sections, including a breakdown and trend.
3. **Robson Classification:** Developed and recommended by the World Health Organisation for accessing, monitoring and comparing caesarean section rates within and between healthcare facilities.

The dashboard has provided our users with additional insight into reviewing the data and to discuss opportunities to improve the quality of patient care.



## Reproductive Technology and Surrogacy Reforms - a Step Closer

The WA Government has recently approved a detailed response to recommendations in the *Review of the WA Human Reproductive Technology Act 1991 and the Surrogacy Act 2008* undertaken by Associate Professor Sonia Allan in 2019. The Government's response was tabled in Parliament on 18 August 2021 and signals the commitment to development of new assisted reproductive technology and surrogacy legislation for WA.

It is intended that contemporary legislation will improve equity of access to assisted reproductive technology and altruistic surrogacy, including consideration of women who face impending infertility, single men, people in same sex relationships, transgender people and intersex people.

Further information can be found [here](#)

# Recognising and Responding to Acute Deterioration

Patient Safety and Clinical Quality

## Recognising and Responding to Clinical Deterioration in Paediatric Patients

Early recognition of patient clinical deterioration followed by a prompt and effective response can minimise the occurrence of adverse events and may reduce the level of intervention required when delays occur. Failure to escalate care for a deteriorating patient can have devastating consequences.

Patient Safety and Clinical Quality Directorate (PSCQ) in partnership with Health Service Providers, will implement a system-wide approach to recognise and respond to clinical deterioration in **paediatric** patients over the next twelve months.

This will include use of standardised Paediatric Acute Recognition and Response Observation Tools, education, training and support for staff and enhancement of escalation systems for families and carers.

The Project is based on a state-wide implementation study co-produced with stakeholders and health consumers, funded by Curtin University and the WA Health Translation Network that involved a [trial](#) in 2019, across six WA hospitals.



# WA Health Services - Recognising Staff Commitment to Safety and Quality

Recognising staff who are committed to safety and quality are a vital part of maintaining a strong safety culture. Several examples of upcoming programs are highlighted below.

**Child and Adolescent Health Service (CAHS)** are running an Inaugural Quality Board Competition in Patient Safety Week 2021. A Quality Board is a display of relevant safety and quality information to facilitate understanding and communication of important topics, trends and strategies. Winners will be announced 16 September and can be found [here](#).

CAHS are also recognising staff passion and commitment to patient safety with their **Safety Award Champion for 2021** which can be found [here](#).

**South Metropolitan Health Service (SMHS), Health and Safety Recognition Program** is an annual event recognising, encouraging and celebrating significant contributions to health and safety performance by SMHS staff. Awards include Best Safety Innovation, Individual Safety Award and Safety Leader Award. Winners will be announced on 11 October 2021 and can be found [here](#).

SMHS staff are welcome to attend the presentation event at Fiona Stanley Hospital on 11 October. Details [here](#).

## Quality Maternity Care continues in the Midwest

**The only difference is the brick and mortar!**

WA Country Health Service (WACHS) midwives are bringing their high-calibre maternity skills back to Geraldton Health Campus from 14 September 2021 after their services were temporarily relocated as part of WACHS' COVID-19 response.

According to Midwest Regional Director Nursing and Midwifery Marie Norris, midwifery teams from Geraldton Health Campus were relocated to St John of God Geraldton Hospital as a protective measure and to allow for additional capacity in case of a surge in patients related to the COVID-19 pandemic.

“It’ll be a smooth and coordinated move and our world-class clinicians will be ready and waiting to safely deliver Midwest bubs back home at Geraldton Health Campus.”



*“The last year has been a great demonstration of public and private collaboration to meet community need”*

# Communicating for Safety

Theatre Team drives positive change

Following a series of SAC 1 events, WACHS Great Southern implemented a successful project to enhance communication to provide a safe and supportive culture within the Albany Health Campus (AHC) theatre team.

In May and August 2021, two full-day workshops were held across multidisciplinary teams. The workshops focussed on topics related to the recognition and response to a deteriorating patient in a theatre setting, communicating for safety, the importance of the Surgical Safety Checklist and human factors in patient safety.

The WACHS Great Southern Patient Safety and Quality team, the Royal Australasian College of Surgeons and key speakers from Anaesthetics, the High Dependency Unit and Perioperative Services were all involved in facilitating concurrent sessions attended by nurses, surgeons and anaesthetists.

AHC Perioperative/Surgical Services Clinical Nurse Manager, Elle Duncan commented that participants have seen great value from the multidisciplinary workshops to understand different points of view and develop stronger teamwork. “The group particularly enjoyed the ‘headbands’ exercise to experience the pressures of role expectations on group performance”, she said.

Ongoing work continues to be done to build multidisciplinary collaboration for patient safety.



**Communicating for safety headbands exercise**

# Psychological Safety - The Gateway to Success

Public Sector Commission

Psychological safety is about creating an environment where staff can speak up, share ideas, ask questions and make mistakes without fear of humiliation or retribution.

Research suggests that organisations with higher levels of psychological safety perform better on almost every metric or key performance indicator, in comparison to organisations that have low psychological safety.

Psychologically safe and inclusive workplaces are also more likely to recruit and retain employees from diverse backgrounds. This is important as the public sector workforce must reflect the diversity of WA to truly represent the community, understand and support its needs.

On 10 August 2021, the Public Sector Commission provided a presentation to PathWest staff across both the metropolitan and regional areas titled *Psychological Safety- The Gateway to success*.

This presentation assisted staff to develop a better understanding of:

- what psychological safety is and the affect it can have on people, teams and organisations
- how to recognise the traits that exhibit a psychologically safe culture; and
- methods to create actions for nurturing psychological safety to improve well-being, collaboration and performance.

## When **psychological safety** is low vs. high

| When it's absent   | When it's high   |
|--|--|
| People tip toe around issues                             | People willing to speak up as issues arise                                 |
| Relationship breakdown                                   | Higher collaboration   |
| Symptoms of problems get resolved instead of root causes | Root cause issues are address to resolve the symptoms of issues that arise |
| People become disengaged                                 | People stay engaged and more motivated                                     |

### Results of high PS

- **40%** lower burnout
- **106%** more energy at work
- **74%** less stress
- **76%** higher engagement
- **41%** higher sense of accomplishment
- **13%** fewer sick days
- **50%** higher productivity

Source: Amy Edmondson, Fearless Organizations; Zak, 2017 - The Neuroscience of Trust

The Public Sector Commission have a range of practical tools and activities for agencies to use in building inclusive and psychologically safe workplaces available [here](#).

# Institute for Health Leadership Clinical Service Improvement Program

## About the Clinical Service Improvement (CSI) Program

As part of WA Health's commitment to invest in clinical leadership, the Institute for Health Leadership (IHL), within the Department of Health, has expanded the long-running Medical Service Improvement Program to support medical, allied health, nursing and midwifery staff to design and complete improvement projects that will impact clinical workflow and provide benefit to their health site.

This Program is designed to foster collaboration and a collective leadership approach to empower junior clinicians from various clinical disciplines to make meaningful improvements and to become strong advocates for safety, quality and service improvement. Previous improvement projects have tackled challenges in surgical processes, discharge planning and communication, and outpatient clinic waiting times.

## Recent Projects

### Proactive CF

Between April to July 2021, Edward Nguyen led a project to consider opportunities to improve the process of cystic fibrosis annual reviews to ensure they are timely, patient-centred and to provide clinicians and parents with a structure care plan to optimise patient experience and patient outcomes. Further information can be found [here](#)



### Gynae Pathways

Rebecca Lewis recently undertook a project to improve referral pathways and communication between Gynaecology Outpatients and Physiotherapy Outpatients at King Edward Memorial Hospital. The Project aligned with the National Safety and Quality Health Service Standard 5 - Comprehensive Care and ensured that medical governance was maintained whilst minimising the unnecessary use of medical resources and focussed on improving patient satisfaction and timeliness of care.

Are you a nurse, midwife, junior doctor or allied health professional looking to develop your leadership and service improvement skills?

**Applications for the 2022 Clinical Service Improvement Program close on 20<sup>th</sup> September 2021.** Visit our [website](#) for further information.

# Australian Commission on Safety and Quality in Health Care

## What's New?

### New National Standards

#### [National Standard for Labelling Dispensed Medicines](#)

This Standard provides guidance for labelling dispensed medicines clearly and consistently. Guidance includes what information to include on the label, where it should be placed on the label, and how it should be formatted to optimise customer understanding for safe and quality medicine use.

Consumers need a good understanding of how and when to take a medicine. This can help them to use their medicines safely and help achieve the best possible health outcomes. Misunderstanding of how to use medicines can lead to unintentional misuse, which may result in harm or adverse health outcomes.

Other standards relating to naming and labelling of medicines can be found [here](#).

#### [Cataract Clinical Care Standard](#)

The new *Cataract Clinical Care Standard* was launched by the Australian Commission on Safety and Quality in Health Care on Tuesday 17th August 2021, via a live-streamed event.

The National Standard will help to define clear pathways of care so that decisions about cataract surgery are more consistent nationally and based on clinical need.

Learn more about Australia's first standard for Cataract's, access the new standard, case studies and other resources at <https://www.safetyandquality.gov.au/cataract-ccs>



### Consultation - Sepsis

#### [Draft Sepsis Clinical Care Standard consultation](#)

The Australian Commission on Safety and Quality in Health Care has released the draft *Sepsis Clinical Care Standard* for public consultation. This new clinical care standard will support a national approach to the treatment of sepsis to ensure that a patient presenting with signs and symptoms of sepsis is recognised early, receives timely treatment and coordinated multidisciplinary care, from first presentation through to discharge and survivorship.

The Commission is seeking comments from clinicians, Health Service Organisations and consumers on the draft clinical care standard and supporting resources until **26th September 2021**. Submissions are requested via online survey, or in writing. The survey link and further details are available at <https://www.surveymonkey.com/r/CCS-sepsis>

### New Publications

Recent publications in safety and quality in health care can be found in the [On the Radar](#) update:

#### Highlights include:

- Fourth Australian report on antimicrobial use and resistance in human health
- Changes in antibiotic prescribing following COVID-19 restrictions: Lessons for post-pandemic antibiotic stewardship
- Rigorous antibiotic stewardship in the hospitalised elderly population: saving lives and decreasing cost of inpatient care.

# Hand Hygiene WA

Audit Period 2 2021



**Overall Compliance**  
85.4%



**Moments**  
26,061



**Organisations**  
57 hospitals  
12 dental clinics



**Medical Compliance**  
75%



**Nurse Compliance**  
89%



**Not met the WA benchmark**  
3



Full results are now available on the public hand hygiene [website](#).

**Next audit period closes on 31 October 2021 (Audit period 3 2021).**

**Mark your calendars!**

## Maternity & Neonatal Care Highlights

## Internal HSP Dashboard



**Overall compliance from the Maternity and Neonatal Departments**

**82%**



**Nursing/Midwifery staff compliance**

**84%**

**Ever wanted to compare your hospital's compliance over time or against another hospital? How much of your hospital's data is submitted by mobile device, could this be improved?**

An internal HSP dashboard is currently in development.

What would you like to see in this dashboard?

Have your say now, email us your suggestions and feedback via [handhygienewa@health.wa.gov.au](mailto:handhygienewa@health.wa.gov.au)

These figures represent compliance across 13 WA hospitals and 1,967 observed critical moments in hand hygiene.

# Upcoming Events

## Values Based Health Care

### Clinical Senate Debate

The Sustainable Health Review Recommendation 16: *Establish a systemwide high value health care partnership with consumers, clinicians and researchers to reduce clinical variation and ensure only treatments with a strong evidence base and value are funded*, will be the focus of the Clinical Senate debate on **22 October 2021**.

The WA Clinical Senate is a respected peak body that brings together clinicians and individuals from all professional disciplines and backgrounds to generate informed, impartial and integrated advice for the Health Executive Committee and wider WA health system on systemwide issues requiring diverse perspectives and innovative thinking.

The October debate will explore the principles of Value-Based Health Care (VBHC) and will enhance members understanding of the concepts of VBHC and how these can be used in line with SHR moving forward.

## Mental Health Week

Given how critical the early years are for lifelong brain development and functioning, learning and wellbeing, the theme for [WA Mental Health Week 2021](#), which runs between **9-16 October 2021** will be *Mental health starts with our children*.

Access to resources and information about upcoming events are available [here](#).

### Networking Event

Time to network with peers, and hear from Tina Bertilone and Ben Hartmann from the Department of Health talking about partnering with consumers on safety and quality indicators. This presentation will consider the challenges of transforming raw data to inform and motivate change and improvements in healthcare for the community. The levels at which data can be used to help patients, help clinicians and help the health system as whole will also be discussed. **Thursday 9 September, 10am–12pm**. Register online [here](#)



**We would love to hear from you. Send us your feedback or queries, and suggest a topic for the next newsletter**

Email: [PSCQ.CED@health.wa.gov.au](mailto:PSCQ.CED@health.wa.gov.au)

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