MELB – Suzie Hooper

We next have a double act and we have Suzie and Kerry and they're going to talk and again, we're not drilling down and we're in Criteria 1, which talks to appropriate use and Larry's really reiterated in great detail the need and now Suzie and Kerry are going to talk to actually establishing governance from a private hospital perspective, which is very important because there is differences and that's been raised by a couple of the questions. Suzie is a group manager of clinical projects, chair of the blood and blood products reference group at St John of God in Melbourne and she's a registered nurse who has worked in a variety of clinical and management roles, including director of nursing and later CEO of a rehabilitation hospital in Frankston in Victoria.

Her current role within St John of God Healthcare is as a group manager clinical projects and that includes working with St John of God, group director of nursing on nursing-related projects including the development of a team model of care, nursing midwifery standards of excellence, nursing midwifery in Allied Health, research counsel and group clinical learning and development and chairing a number of clinical reference groups including the blood and blood products reference group. She holds a Master of Nursing Leadership and was awarded the Catholic Health Australian Nurse of the Year in 2009.

Her offsider is Kerry. She's a transfusion nurse at St John of God. She's a registered nurse who has extensive experience in oncology, haematology and palliative care fields. Has worked in both public and private healthcare facilities in management education clinical roles. Thank you very much for both joining us and please, we look forward to what you've got to say.

Kerry and I perhaps bring a reasonably unique perspective to the establishment of transfusing governance because we are a national organisation with large hospitals and small hospitals and a significant variety across the country. Just to acknowledge that we certainly don't have any financial interests or endorsement of any products and that we'd also very much like to acknowledge our colleagues and peers who have shared their knowledge and experience with us because our journey in all of this work, is always informed by the practice and knowledge of others so we don't pretend to know it all by any means. Just to set the scene a little about St John of God Healthcare, we are a Catholic healthcare organisation.

As a consequence, we have a Christian vision and mission that informs what we do and part of our vision is around inviting people to discover the richness and fullness of their lives and certainly the way that we provide our clinical care and care for them in a safe and practical way is integral to that. So this work around transfusion practice is, of course, really important in ensuring that we provide the best and safe care and fulfil the vision and mission that we espouse to. Our values guide, how we deliver our mission, is an organisation and you can see that we have five of them there and that is compassion, excellence, hospitality, justice and respect.

There's a whole bunch of criteria that sit within those values but under our excellence value, we have a very core criteria around stewardship and we

believe that the way we work with all of the resources that we have to provide our clinical care, is a stewardship is fundamental to that and so this work that we're talking about today and particularly in patient management of blood, is really very much focused on our stewardship responsibility. So who we are? This is information from our 2011 and 12 annual report. And we're a fairly old organisation established back in the late 1800s in Western Australia by a group of religious sisters from the sisters of St John of God. They were Irish nuns that came out from Ireland at the call of the bishop to help in the typhoid epidemic in the Western Australian goldfields. And then they spread their wings far and wide from there.

We're now Australia's third largest private hospital operator and we employ close on 10,000 caregivers across our organisation. And we run home nursing services and you can see we treat a lot of overnight and same day patients and a significant amount of those are surgical patients and probably too many of them have single transfusions I suspect. We deliver a lot of babies and hopefully not too many of those women have blood transfusions. You can see here we we're situated and we have 13 hospitals, around 2000 beds and we also have very significant social outreach services across our organisation as well. Our social justice initiatives are, again, an integral part of who we are and what we do and this is not negotiable for St John of God.

We must commit a certain amount of revenue to social justice activities to fulfill our mission. So our background to the development of our blood and blood products reference group and our governance system around the standards generally, is that we've always had a really strong commitment to ensuring provision and safety of quality around clinical care and this obviously includes blood and blood products. And in 2008, we established our group acquired transfusion group and that was setup as a result of a review of clinical practice across the group and under the auspices of our group director of medical services and our group director of nursing, this reference group was established and it's been a work in progress since that time and then of course, the new 10 quality standards have provided us with a whole new framework in how to work with these groups.

So we also have reference groups for all of the 10 quality standards and I chair three of them, that being blood reference group, the falls reference group and the pressure injury reference group. So this is a very established process for us in every division and we call our hospitals divisions, has a representative at the table for the transfusion reference group and all the other ones. And the purpose of the transfusion reference group initially was that we would have a group approach to development of policy. We would facilitate education and training around the provision of blood and blood products, auditing and reporting and the executive sponsor for this reference group was the group director of nursing and as I said, we had divisions.

And then along came the standards and we undertook a process as I said, of developing our reference groups for all of our 10 standards and the transfusion reference group morphed into the blood and blood products reference group. We were very keen to reflect in our reference groups exactly what the standards were asking of us. So that's why the names were changed to reflect and we used the symbol in all of our documentation around these references groups. Along with the development of the standards, we then undertook organizationally a review of

how we manage clinical governance in our organisation and the clinical governance framework is comprised of two key elements.

And this clinical governance framework was developed at the highest level of the organisation so the group director of medical services is responsible for overseeing this framework. And it went up through what we call our group management counsel and then through to the board and was signed off by the board. So the board has taken the compliance with the 10 standards incredibly seriously and it's certainly set the cat amongst the pigeons. There was no doubt about that. Everybody was scurrying as I'm sure many of you have been as well to understand the standards, what they meant for us, what they meant for clinical practice and how we could enable the compliance. So we have as I said, in our clinical governance framework, we have two elements.

We have structural elements, which are the external and the legislative requirements that drive our framework and our clinical care obviously and then our internal structures, which includes the roles and responsibilities and I'll show you the framework in a minute. The enabling elements that then facilitate this is done through directing. So the strategy framework's policies that direct clinical governance and they're related to activities right across our organisation. Controlling and management so there's systems and processes where the caregivers work to ensure the delivery of our care and then assuring so that the outputs and measurements of the effectiveness of the directing and the controlling elements.

So our framework looks this and you can see on the left hand side that you're looking, the structural elements that exist there and I've circled the ones that are key to blood and blood transfusion and so we have the group management committee sitting under St John of God group and we have all of those group elements in which the blood and blood products reference group has some reporting responsibility. So we have the group clinical risk and quality committee. We have the divisional management committee and that should be down further, divisional clinical risk and quality managers. So it's from the highest level of the organisation right down to the divisional groups. And that's, as you know in the standards, one of the key things that we must demonstrate is that the reporting line's up and down at the highest level of the organisation as well as at the clinical bedside level.

And then the enabling elements that help this to happen then, is obviously, the accreditation management system, our divisional clinical quality auditing system and our clinical reference groups. And also down the bottom there, you'll see the clinical governance learning development program. So we have also engaged very actively through all of the 10 standards, how are we facilitating the learning for all of our clinicians to enable compliance with the standards. And then we also have our quality assurance program and those circles aren't where they're meant to be. I'm sorry about that. They moved. So we have the group clinical governance assurance program and we also have, it should be review and patient client complaints reporting and it should also be the divisional clinical quality audit program, which is really integral and I'm sure you've all been immersed in auditing against the standards at some level and it's been quite overwhelming and we've done a lot of work around how can we make that process a whole lot easier.

So getting sort of down to the level of our blood and blood products reference group, which is a key element, we now have redefined our terms of reference so that they reflect the standard and the requirements of the standard. We have defined roles and responsibilities for the chair, so my role and also for each of the representatives and they're very clearly aligned directly back to the standards so that each member of that reference group understands what it is they are required to do because that's changed now that we have the standards. And it was interesting as we transitioned from the previous reference groups to these new standards-based reference groups but some of the people who were the original representatives, actually found it quite overwhelming and didn't want to be responsible anymore at that level.

So it was interesting that, at times, people were perhaps sitting on committees because somebody told them they ought to, rather than that they actually had an actual commitment to fulfilling the requirements of the role. Not so much in this reference group I have to say. Pretty well everybody has stayed who was previously on the transfusion reference group. We also have across the group, tried to standardize as much as we can because I'm sure you're very familiar with the standard that it is quite clear about what needs to be achieved. So we didn't want all of our hospitals trying to do something different and wasting energy around things that could be very easily standardized. So down to the point where we have standardized agenda and minutes templates for all our reference groups so that it all looks the same.

Our terms of reference have been provided in accordance with the relevant guidelines etcetera so that we're ensuring that we're providing evidence-based practice and they have a very clear responsibility to provide advice and make recommendation back to the entire group. And the group that they report through to, this reference group reports through to is all of our directors of nursing. So they hold responsibility for clinical service provision in our organisations and therefore, we need to report back through them, so in all matters relating to administration management of blood and blood products so it's an important responsibility and that reporting line is really important. Our group director of nursing chairs what we call the GNLT group nursing leadership team and she sits on the group management committee that reports through to the board. So again, we have that reporting line straight back through to our board.

And the roles and responsibilities for myself as chair of that committee, that I report directly through to the executive sponsor, that I am responsible for facilitating the business of our group and I chair the meetings and so on you can see. And policy development is a significant part of my role. And I'm the conduit also to our group quality and risk committee. And I think, you know, the emphasis that previous speakers have put on, that this sits within a risk management framework is really, really important. That it's not sitting out there on its own. It sits under that umbrella of risk. And our divisional representatives have an important responsibility to disseminate information down and bring information back up. And they are appointed by their DON. They are there to provide advice and guidance and Kerry will talk a lot more about that in part of this discussion.

The lucky ones that get to facilitate auditing of compliance with Standard 7 and that's been a journey all on its own and Kerry, again, will talk a little about that. They also are required to develop a divisional action plan from the audit results.

Previously, wave had a lot of problems around people doing lovely audits and the audit sitting in the drawer and not much else happening with that. So we've really got some clear guidelines about audits are not for drawers. And you can see the rest of the responsibilities there. And the auditing process, as I said this has been quite a daunting process and I'm sure many of you have been involved, particularly if you're heading towards accreditation in the near future, that we originally utilized the standard audit forms that were developed by Queensland Health. I'm not sure if some of you are familiar with that but totally across all of the 10 standards we worked out there was about 1038 questions across all of those audits and everybody was spinning heads and going crazy with the amount of work that it was creating.

And we were auditing at divisional, unit and patient levels and that was completed by our reps. And then we have a centralised data collation and analysis reporting to go back to the divisions. Bu what we're now realising is that, in fact, a lot of the higher level divisional and group questions apply across all the standards so we're actually now going through a process of changing all of those audit forms and our group clinical risk manager has managed to get 1000 questions down to about 53 across all of the 10 standards so we're about to roll out that new process. In terms of caregiver education across the group, we have certainly utilised the blood safety learning and our biggest challenge is the VMOs that was spoken about earlier. They're just a challenge.

I was interested to hear they'll all die soon. I don't think it's going to solve our problem in the private sector because all of our doctors are VMOs apart from very few employed doctors so it is incredibly challenging and so we have a lot of work to do through our group director of medical services and risk through our medical advisory committees, that we're going to go from a top down approach rather than a bottom up. So in terms of consumer information, we have a way to go in terms of consumer engagement and that's quite challenging. One of the things that we have done is that we have now rolled out bedside handover right across our organisation as a standard process and part of that process is engaging with the consumers at the bedside during the handover process. And all matters clinical pertaining to the standards are supposed to be discussed with the patient and we're actually developing up a peer review process around bedside handover to see that we are working in that engagement area.

We do use the Victorian Blood Transfusion, have all your questions been answered and Kerry will talk a little bit more about that process of coming to the decision to use this group wide and how we went about that. And that was through a consumer engagement process. Our challenges, our meetings are Australia-wide. They're held via teleconference and that's always a challenging thing. Gaining consensus is endlessly challenging when you're dealing with 13 hospitals across Australia. Standardisation of policy across the group has nearly sent us spare and Kerry will talk a little more about that but we had to review our policy against the standards and make sure that it reflected the standards. One of the interesting things, when you have a multi-site organisation is that they love to develop their own policies. The group policy is never good enough and we've got to change it a bit for us, so trying to get people to stop doing that has been very challenging. We think we're there.

Consent is an incredibly difficult challenge for us. Even getting consensus about a standard consent form, every division has a different form. So we're doing a lot

of work on that and also around blood prescription form. Collecting clinical indicators has also been a challenge. These are the three ACHS clinical indicators that we have nominated to be collected obviously, in relation to blood and blood transfusion. 6.3 is the one and given our previous speaker's discussion around inappropriate use of blood products, 6.3 is proving to be the most difficult clinical indicator to collect and the most pushed back from the division, so we have quite a lot of work to do around that. We also have now, obviously, the indicator from the standards and it's number 12 and that's wastage of blood and blood products, so we're developing a process around collecting that group-wise.

So in terms of how we have worked as an organisation to facilitate this group-wide approach, it's been through a lot of persistence but also through the process of getting some momentum going and I thought I'd lighten things a little bit around the importance of when you're going through a change process that we have been, it's not a single event and it takes great leadership. So I'll just share this video with you for one moment. So I share that with you because I suspect many of you are the lone nuts in your organisations and trying to drive that change is really, really hard and hopefully you've got a follower right beside you. So in terms of out transfusion nurse role, all our DONs agreed that there was a need for a group approach to facilitating best practice but it required the ability to provide leadership and expertise and so our lone nut came on board and that was originally Ann Kinmonth who is in the audience today and she has been ably followed by our next speaker Kerry.

The role was supported by the group director of nursing and it's now supported by the blood and blood reference group, chair, myself and Kate as our group director of nursing executive sponsor. But I think it's really important that that video tells us that it's about having the courage to stand up and say what needs to be said and particularly around this issue of wastage and so you really do need to be the lone nuts that take us to that next step.