SYD - Sally Francis

… background and whilst working as a care coordinator for adults and children with congenital haemoglobin disorders developed a passion for transfusion safety and understanding and improvement of transfusion medicine practices. After working as a clinical nurse consultant in transfusion medicine within the Northern Sydney Central Coast Area Health Service she moved to clinical quality and safety roles at Royal North Shore and then St Vincent's Hospital Sydney. She has recently returned to the fold as the program leader for New South Wales clinical excellence commission, transfusion medicine improvement program Blood Watch. It's a great privilege, please make Sally welcome.

Thank you. I've been given instructions on how to use this. For those of you who know me and work with me you know I'll take every opportunity to break something so I promise that I'll try not to.

Thank you for asking me to talk today. I'd just particularly like to thank you for the after lunch before morning tea session. Thank you. I've put a lot of animation and there'll be a quiz so it's hard for you to fall asleep when you're dizzy. Just so you know I'm joking about the quiz.

I'll give you a little bit of background I'm working for the Clinical Excellence Commission for the Blood Watch program, Caroline Devatanion and Bernie Harrison started working on this program in 2006 so I'm standing on the shoulders of giants. We work on the premise that our aims are to improve transfusion medicine practice in New South Wales and we do that by actually supporting local initiatives and local work. We've got some key partners in terms of the Ministry of Health in the Blood Service, NBA but our main partners are you guys, local. I've been coming back into the fold too. Just wanted to point out it's wonderful to see so many familiar faces in the crowd but it's even more heartening to see so many people that I don't know, so welcome aboard. That's all I can say.

So I'm going to talk to you today about documentation. There's a couple of little things to point out. I'm going to give you some examples of documentational things that have been put in place around documentation and some of those you can actually take away and use yourselves if you think that is appropriate. I'm going to give you an example or two that you would not be able to take away but the real key here is and this is wearing your patient safety and quality hat. Safety and clinical quality is local and that's the interaction between the clinicians and the patients. It's interaction clinicians working together on the ward, it's multiple interactions that occur in a health service. So while some of these examples may be useful some of them may not be.

Okay. The other thing, what, one of the things that I like to note, one of the things that I like to talk about, one of the questions I like to ask is why. Why is this important? It's why, as Philip pointed out earlier, who owns this? Who is this important to? Who needs to run with this? Who wants to improve this and what does it actually mean? Okay. So I went off on a bit of a journey, first of all sent a random email out to most of my program contacts, so local contacts sort of kind of like "so what ya doing, what do you do". Because I don't own documentation

at a local level. It really is local and it's different everywhere. It's very interesting.

So I got a lot of feedback and I would like to thank those people first, particularly Daniel for reminding me to wear my lipstick, you're going to be on film. If I wanted to put down a thank you to everybody who participates and helps out this slide would be in about four font and you wouldn't be able to read it so I'm not missing out on anybody, these are just the key people that really gave me some either feedback, some ideas and some information and allowed me to vent when I came across a couple of other things.

So getting back to documentation I kind of started to go on a little bit of a journey and I got lost in medical blog world. Has anybody ever found themselves following medical blogs around physicians and "why do I have to do this". (04.23) Why do I have to do this? It's all about funding. It's all about ABF. It's just a checklist, how is this helping me do my work. It's just about auditing. It's just so the quality people can come in and just double check and make sure that I'm doing my job but it's not and luckily we've got some local experts here that recently published what I think is the best reason for documentation that I have seen in one very well constructed paragraph. And I really like it because it's about the patients. Purely about the patients. It's about the patient's journey through our system. It's about what we are doing around the patient. So appropriate clinical decision making. These are all things that we've heard before.

Audit is important because it helps us understand what we're doing and it helps us improve our future practice. It can't be ignored. Adverse reactions, one of my passions. Special product requirements in transfusion laboratories. The thing there and one of the things that you'll see shortly is that documentation belongs to everybody. So what does that look like? The practicalities of it. Okay. In New South Wales we have a policy directive. This one was published in 2012. Similar to previous ones and that sort of has an overarching statement there. The reasons for patient requiring a blood transfusion should be recorded and the records relating to the patient. That's a fairly straightforward statement to mind.

Some of our evidence based practice. We have guidelines for the administration of blood products summarised. Reasonable list of information that must be documented. Getting a little bit more complex. A little bit more detail, what does that look like. We also have the guidelines for pre transfusion laboratory practice. Currently these are under review. I can't imagine the documentation elements are going to change significantly. So we have some of the requirements around request forms written down and electronic. And some of the requirements around the patient records. Okay. And some of the requirements around compatibility issues and reports. A lot of information.

Then we have standard seven and I think this nicely summarises and pulls it altogether. It actually outlines what we would reasonably expect to document to provide evidence that we are providing a safe and quality service because that's what it's about. Providing a safe and quality service. So that's pretty simple yeah? Everybody's got that? I'm done, I can go?

Okay. So it actually is quite complicated. It's not a simple linear process at all. It's not as simple as just writing in the patient record. There's a whole lot of things that need to be done. So putting my quality hat back on again. I thought

I'd have a go at process mapping it because if you can't process map it, it didn't happen.

Right, so this is actually probably about the fifth literation. I borrowed some work from some other colleagues of mine and I've actually removed a lot of it. I tried to simplify it. Really synthesise it down to the elements that are discussed in our evidence base guidelines. Okay. I've taken a lot of the no's out as well and there's a few things that really are quite key here. One is number of opportunities where we need to document something and some of these are not just one documentation. We're actually documenting a whole lot of different elements within that documentation. So there is a number of them. It's not linear. There is clear medical, clear nursing, medical laboratory, laboratory, laboratory nursing for that one and then we come back and this is probably all three. Okay.

So again I think the reason I wanted to show you this is that it's not linear and it is complex and there's a lot of opportunities to not comply with what we're required to do. There's a lot of opportunities there to improve it. The other thing that's important about this particular process and I find this with probably documentation more than anything, it's very cultural. It's very much owned. The way we document is very much, it's like our verbal communication, it's very much owned by the people who use it. Okay. And that's important to know because that's really going to be your in on how you're going to understand it and improve it.

So what I wanted to talk to you today about, I wanted to give you, going back in history because if we don't learn from history we'll never move on. I want to show you some evidence of how this has been applied globally in New South Wales but also some of the local opportunities and it's not going to be all of them because there has been a lot of work done in various places across New South Wales. This is just some of them. Okay. So for anyone here who's done a great work and I haven't included it, not because I'm not deliberately not including you, these are just really examples. And I wanted to show you how different they all are, that's the other thing. I also want to show you some of the challenges that we're going to have. That we're actually having already in the future. So I did like Deb's slide better with the cycle, then I should have kept my quality hat on. It's basically a plan, do, see, act cycle but this is nice enough. We need to understand and assess our risk. We need to identify opportunities, implement and then measure. And this doesn't just happen once. It's a true cycle. It goes on and on and on. Okay.

So in New South Wales the evidence of a problem. So 2007 a lot of red cell, when the CEC project or program was implemented when all the area health services had programs in place, so you've heard about Northern Sydney Central Coast now. When we had the seven area health services a lot of this work was done across the entire state. We looked at a whole range of different things, a whole lot of different places, a whole lot of different types of hospitals, a whole lot of different types of patients. But we actually only looked at red cells. So assuming red cells is a big key here, it's the biggest product. So in 2007 we found that we had a massive variation and documented consent. So between 10 and 95%. In the instance variation not good.

We noticed there was a variation between hospitals. So some hospitals had great consent some didn't. Interestingly quite good compliance with consent in

the surgical population. Very poor compliance in the medical population. Is anybody surprised by that? No, okay. This is still an ongoing challenge for us. When we looked at other documentation, I looked at only about 40% compliance with documentation. This is in the client records, so the patient medical record. So really not good enough so we needed to do a bit of work. And a lot of work was done and some of it was done across the state but some of it was done, a lot of it was actually done really locally. When I looked at it again in 2009 we had 60 to 100% documented consent. So this is documented consent, this is not, we weren't looking at the quality of the consent and as Mark rightly pointed out earlier there were some issues about the way we looked at that but that's okay. But we didn't really find a significant difference in the compliance of the documentation, okay. And that was after two years of work. Quite intensive work across New South Wales.

So consent just to start was just easy. We probably were lucky in New South Wales compared to other jurisdictions in that we had a policy directive around consent to medical treatment and it had a simple statement in it that said specified blood transfusion as one of those special interventions that required consent. So really the challenge for us was actually implementing an already implemented policy. It not quite that different. We try not to introduce anything new. And we were also provided with a form that's actually part of the policy directive. We've already seen this morning that there are some issues with that form. That's okay. But at the time this form, types of form were implemented so we were able to tick that box. Again we weren't actually looking at quality. Just looking at the fact that it was documented in the notes.

However our big problem was the documentation. So it was effectively the rest of it. So this did not only vary between hospitals but between speciality groups within hospital. So in one large hospital you might look at orthopaedics and gastro and cardiothoracic and every single one of them would be completely different. Interesting questions given that you'd think that most of this documentation has been done by junior medical officers and they rotate and so they might actually move from an area of good practice of poor practice and why is that practice not being taken with them. When that kind of thing happens it tells you that it's really about that cultural, it's a really good way to look at how local ownership of documentation is. Multiple owners of different types of documentation and I mentioned this before, that the process that I pulled up before, not everybody has access to each of those different types of documentation so it often feels like it's repetitive. So if I'm writing something on a form why then do I have to write it in the notes and then why do I have to write it on that form when the labs just going to put in their system and they're going to put it in their system and I don't have access to it because when I pull up my pathology results it's not there. So it's really actually quite difficult. As I said it's not linear, it's not necessarily connected and it's finding out who owns it.

Improvement is local and a context is the key. That's really important to remember. So some of the things that were done. So this is just one hospital. A red cell audit identified that they only had 30% consent so they had about a 51% compliance with documentation. Over a 12 month period there were a couple of different things that were implemented to improve that. One of those things was an initiative around the sticker (15.40) in the medical record because that had been successfully implemented somewhere else. But in this context it really didn't have an impact at all. So we really didn't have a significant increase in

consent and not a significant increase in compliance with documentation requirements.

So this is one of the hospitals that implemented a form. This is a form that combined the medical element of documentation and part of the nursing element of documentation. You'll note it doesn't have observations on it or fluid balance chart. What we do have is indication. So clinical indication. We also have consent and that single episode consent but there also an opportunity to complete this for long term and chronic patients who may have a longer time period of getting treatment before they're required to get consent. There's also a checklist around the patient identification and the verification of the product and the signature when it was started and this actually complies with all of the requirements.

So how did this work for them? Effectively, so that's after two cycles of implementing problems with no significant, we start to see an improvement. In fact in 2013 there's 100% compliance with that documentation. That looks fantastic but it is not the documentation of all of the elements that are required. So this is not compatibility, so the traceability that needs to stay with the patient records. It's not the observations, it's not the fluid chart so it's literally just the two birds with one stone, it's not going to solve everybody's challenges. But very effective.

Another different issue that we know is being looked at. So one large area health service, again this is back when we had large area health service, seven hospitals, two teaching, so 824 audits over a two year period so retrospectively reviewed to see if there was a problem identified with that transfusion. The problem was defined roughly in the context of In's (18.33), most of that incident management, so where there was an outcome and this was an actual outcome, so we didn't actually look at the near misses, an actual outcome where there was harm however small to the patient as a result of the transfusion. So we found 6.7% of those audited records had a problem identified. Another large area health service did a similar study with a very large number of audits and came up with almost essentially the same fear.

Big problem was we do have incident management that's a voluntary reporting, so we have In's (19.10) voluntary reporting and we do know that there is a big difference between what actually happens and what goes into the incident reporting system. We think in transfusion medicine we've got issues with if this is a known risk, is it an incident type of thinking. So there's a lot of things that need to be looked at in terms of that but here's the evidence for it. Interestingly, so we know that we had 6.7% of the events were not put in our incident management system and they were, when you looked at the clinical record there was a significant range of not documenting that event at all to being very well documented and then it ranged from all of it. It ranged across all of the different, could be just a little bit patient, you know, the tachycardic, you know, very limited. So that was a big problem.

So what actually was implemented and I'm just going to show you the system response to this not just the documentation. So this is Central Coast which was part of the area health service. They kindly gave me their newer version but similar type of thing. Basically a procedure, this is a very short procedure. It's very clear. Key part of that is that there's an expected outcome that will manage

those patients, they'll be identified and they'll be managed but they'll also be monitored. So they'll be built into the governance of the transfusion management system however it's going to look and that's really important. And it was actually accompanied by a form because a form works in this instance. I have seen other documentation say with falls or pressure injuries where there's actually a sticker. And again it's very local. Is a sticker going to work in that environment? Is a sticker going to be something that works? So this actually went across the area health service and there was a whole lot of different things. There was the clinical management but also the documentation of it. And that's still in place. It's still in place in the two separate and it's being used in most hospitals. We've got, I think it's only the one small hospital that's not using it and we probably really need to understand why. It needs to come back full circle. Why is that form not being used in that hospital? Have to understand and assess our risk.

I did see an increase in incident reporting although it didn't ever quite correlate. Could not ever get it quite back together again. One of the problems that we think is occurring is that there's the identification, is probably the main risk there and that actually comes in under other elements of the standard around haemovigilance and how that works. But it's continually monitored, very important.

Now this is an example here where probably not transferable but I really like the thinking outside of the box here. So we've already heard discussion, I would love to talk to you less about how you manage to do that because …

It was their idea.

It was their idea, okay. Just curious. Albumex. So we've already provided in bulk lots to intensive care units and operating theatres. It isn't a common practice, doesn't happen everywhere. It's generally a work load issue for both the laboratory and the intensive care environments, the operating theatre environments as in this is something that is just part of the way that they work. So they don't want to be coming to you all the time and vice versa. So what it means is effectively Albumex has been relief from the laboratories not on a named patient basis. So the capacity to link, traceability of products and the capacity to actually build that back in and document a transfusion history can't be done.

So I like this, this hospital and it really is again (23.27) this medication, electronic medication prescribing. So what they've done is they've built Albumex into the medication prescribing system. It's not dispensed by pharmacy, it is still a blood component, it is released from the transfusion laboratory but there's instructions there about how to actually obtain it. And to sign it off you need to put the lot number in, into the medication chart. So it's all electronic. They've done this with the immunoglobulins as well. So what does that mean? So it's not transferable, I'm sorry. But that's now traceable back to the patients because effectively you can run a report that has and I've blacked out sorry the patient MRN (24.18) and the patient name but the product and the batch number and how much they got. So linked all the systems back together. I'd love for that to be able to be shared but sorry.

So some of the things that are coming along everywhere and one of the things that I'd like to point out where efforts have been really made to tie it altogether.

So to bring this disparate ownership around documentation to tie it all together. To make it a little bit more linear, to make it flow, to make it less double entry, to make it less paper based is the electronic records EMR's. So most sites now will have an EMR order, a cross match with some documentation that's automatically put in, some of it's free text. Feed into a laboratory information system transfusion history. This is just an example of one of the (25.34) funds. And we can actually build some documentation in there which is around the reason, how much they got, what they had and if there was any problems with it.

There's some challenges here for us though. Speaking to various people we have either free text where a space or a comma or a full stop can be put it in so that they can move onto the next field which is a problem. Some of those that have the systems where they don't allow that there is actually something that the documented reasons don't actually align with the clinical indications or how we want to use them. I don't know about anybody else but this one, that's actually really not telling me anything about the patient and about what that patient needs or what decision or what care planning is being done around that patient. And I think that's probably too limit for a transfusion reaction. I just want to show you an example and it's quite interesting that the forms, I thought everybody had forgotten about the forms because we all print them off a power chart these days but Mark brought up the old form and in Queensland looking at theirs, we have forgotten about the forms and that actual written communication between the person who is ordering group and holding cost match to the laboratory staff. That information was never collected. Did never go anywhere. You can scan the form into the system but nobody ever analysed it or looked at it so we thought we'd give that one a go as well. So we did look at it and we looked at thousands of them and we looked across five hospitals and we identified that across all the five hospitals only 27.7% of those forms had a documented, had adequate documentation on what we would consider to be all of them.

Interestingly transfusion history was very rarely completed. It was completed by the pathology service of phlebotomists always but anybody else it very rarely got done. Which is interesting because in a lot of instances, in fact in most instances, patient presenting to hospital will not have a transfusion history at that hospital so the only way to get that information is to ask the patient when you taking, that's just not being collected and 32.4% on a cross match. So it's quite close with medical and laboratory staff with the medical staff incorporated into a whole range of orientation opportunity, so for example going to ED orientation for new registrars every ten weeks and we had five minutes and there was three things that we were allowed to say. Those kinds of things. So over 18 months that improved. Not great but it improved. A lot of work was done. Is it sustainable, it's very labour intensive. And we have now the introduction of EMR so any gains that we did get out of that no longer apply and it's a new platform but it's the same behaviour. So the EMR is often being, you know this is going to save the world, no, no, we actually haven't changed the people who are using the system really. And so we've actually got, recently looking at that, it's all come undone. So some of the things that you need to think about.

So there's no real easy solution to improving documentation. The key really is understanding what it looks like, what opportunities there are to improve it. Where it's not working or where it's not meeting the needs of the patient and continuously monitoring. Most of these things have been monitored and looked at regularly over years, so not just one off, years. Continually monitored,

continually fed back and changed and adapted if needed. And learning from failure is often as important as learning from wins. Thank you.

Thank you Sally. Questions, comments?

Look just in relation to the data that you collect and we do have a two tiered system, we have a private system here, how does the private system match to the public or vice versa? Do we have any details in relation to that in terms of wastage etc and that possible cost impact on the health system?

Well in terms of wastage yes, having spoken before. The big opportunity for some of the clinical things that we look at is in those hospitals that have collocated or the laboratories have a co relationship with a private hospital. So there is work has been done around looking at that. Probably though what we're looking at is systems that are the same. So it's when you actually start getting the greater disparity in the systems that makes it much harder to look at and compare it. So you can look at it but it's actually being able to compare it and benchmark and do all that kind of thing. I think that's the opportunity we lose.

Okay. Thanks.

Thank you. Questions? Fantastic. Sally on behalf of everyone here thank you very much for your time and your presentation.