RWH Hysterectomies – How do we compare?

Women’s Hospitals Australasia (WHA) is an association representing all major women’s hospitals and health units in Australia and New Zealand, and acts as a peak advocacy group for women and neonates. As part of a broader project to compare the processes and outcomes of public gynaecology services, WHA last year co-ordinated a benchmarking exercise on hysterectomies performed for non-malignant indications. This took the form of a retrospective audit of medical records of patients discharged between 1 July and 31 December 2006 (inclusive).

The audit aimed to identify:
- characteristics of women undergoing hysterectomy for benign disease
- process to decide hysterectomy as treatment
- process to decide procedure used, and
- morbidity of the procedure.

Process

Representatives of participating WHA institutions met to determine the data set to be collected by the audit, which included:
- patient’s age and ASA score
- history of caesarean section and/or gynaecological surgery
- treatments offered prior to hysterectomy
- indication for hysterectomy
- planned and actual approach for hysterectomy (TLH, TAH, etc.)
- designation of primary operator (consultant, reg, etc.)
- duration of operation and of hospital stay
- blood transfusion and/or other complications

Cases to be included were identified using ICD-10 codes for hysterectomies without a malignancy diagnosis. Hysterectomies performed perinatally or as an emergency were excluded. Data were collected from medical records, electronic pathology results programs and theatre databases.

Results

Data were obtained from five health services:
- Mater Misericordiae, Brisbane (51 cases)
- Al Corniche Hospital, United Arab Emirates (13 cases)
- Flinders Medical Centre, Adelaide (41 cases)
- King Edward Memorial Hospital, Perth (130 cases)
- The Royal Women’s Hospital, Melbourne (152 cases)

The total number of cases reviewed was 387. The average age of patients was 50; 15% had a history of caesarean section. Mirena had been tried in 23% of patients (29% at RWH). The commonest primary indications for hysterectomy were:
- fibroids 34% (43% at RWH)
- prolapse 21% (28% at RWH)
- dysfunctional uterine bleeding 18% (10% at RWH)
- cancer prophylaxis 13% (16% at RWH)

The patient’s ASA score was less than III in 87% of cases (95% at RWH), and postoperative complications were rare overall, the commonest being anaemia, with 25 patients so affected (10 at RWH). A blood transfusion was administered to 7% of patients (5% at RWH).
Discussion

This audit provides an interesting descriptive snapshot of patients undergoing hysterectomies for benign indications, and should serve as a useful starting point for future potential benchmarking exercises. It has a number of limitations, the most significant being:

• non-standardised terminology between institutions, particularly relating to the primary indication for hysterectomy
• the (general) paucity of information in medical records about patients’ past gynaecological care (especially if delivered elsewhere), and the rationale for planning a particular approach for hysterectomy
• the inclusion of patients who had additional procedures performed at the time of hysterectomy (e.g. vaginal repair), without accounting for these in lengths of stay, complications, etc.

A prospective benchmarking exercise could address these limitations, thereby producing statistically robust data that facilitate valid comparisons between institutions, and allow for the development of best-practice targets. WHA will integrate feedback from member institutions in developing such an exercise in 2008. As maternity services have shown, systematic ongoing audit can play a significant role in improving patient outcomes; it is anticipated that similar activities in the gynaecology arena will produce similar benefits.

— Stefan C Kane

The following table facilitates comparison between the four modes of hysterectomy at the five health services for the parameters listed:

<table>
<thead>
<tr>
<th>Hysterectomy Procedures</th>
<th>AI Corniche (UAE)</th>
<th>FMC (SA)</th>
<th>KEMH (WA)</th>
<th>MMH (QLD)</th>
<th>RWH (VIC)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Abdominal Hysterectomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number (% of total)</td>
<td>11 (84.6)</td>
<td>22 (53.7)</td>
<td>63 (48.5)</td>
<td>24 (47.1)</td>
<td>77 (50.7)</td>
<td>197 (50.9)</td>
</tr>
<tr>
<td>Average time of surgery (hrs)</td>
<td>1.52</td>
<td>1.97</td>
<td>2.04</td>
<td>1.64</td>
<td>1.58</td>
<td>1.78</td>
</tr>
<tr>
<td>Average LOS (hrs)</td>
<td>124.17</td>
<td>129.65</td>
<td>140.04</td>
<td>93.64</td>
<td>102.27</td>
<td>117.46</td>
</tr>
<tr>
<td>Average age of women (yrs)</td>
<td>45.22</td>
<td>47.78</td>
<td>49.66</td>
<td>51.25</td>
<td>48.03</td>
<td>48.83</td>
</tr>
<tr>
<td>Number with weight of uterus provided</td>
<td>1</td>
<td>19</td>
<td>60</td>
<td>18</td>
<td>68</td>
<td>166</td>
</tr>
<tr>
<td>Average weight of uterus (g)</td>
<td>1801</td>
<td>177</td>
<td>508.03</td>
<td>171.71</td>
<td>600.62</td>
<td>479.39</td>
</tr>
</tbody>
</table>

Excludes outlier with LOS of > 2 mths

Laparoscopically Assisted Vaginal Hysterectomy

| Number (% of total)                     | 5 (12.2)         | 10 (7.7) | 2 (3.9)   | 4 (2.6)   | 4 (2.7)   | 21 (5.4) |
| Average time of surgery (hrs)           | 3.65             | 2.58     | 1.39      | 2.48      | 2.7       | 2.7    |
| Average LOS (hrs)                       | 95.81            | 81.27    | 47.61     | 42.76     | 43.29     | 80.29  |
| Average age of women (yrs)              | 48.01            | 42.34    | 37.25     | 42.76     | 43.29     | 43.29  |
| Number with weight of uterus provided   | 4                 | 10       | 4         | 18        | 18        | 18     |
| Average weight of uterus (g)            | 150              | 190.7    | 253.5     | 195.61    | 195.61    | 195.61 |

Vaginal Hysterectomy

| Number (% of total)                     | 2 (15.4)         | 2 (4.9)  | 35 (26.9) | 20 (39.2) | 54 (35.5) | 113 (29.2) |
| Average time of surgery (hrs)           | 1.81             | 2.15     | 1.59      | 1.2       | 1.74      | 1.6    |
| Average LOS (hrs)                       | 111.63           | 87.17    | 87.56     | 86.35     | 78.67     | 83.52  |
| Average age of women (yrs)              | 55.82            | 75.88    | 53.15     | 50.88     | 55.7      | 54.42  |
| Number with weight of uterus provided   | 1                | 34       | 12        | 46        | 93        | 93     |
| Average weight of uterus (g)            | 87               | 100.62   | 170.94    | 110.02    | 114.2     | 114.2  |

Total Laparoscopic Hysterectomy

| Number (% of total)                     | 12 (29.3)        | 22 (16.9) | 5 (9.8)   | 17 (11.2) | 56 (14.5) | 118 (24) |
| Average time of surgery (hrs)           | 3.09             | 2.5       | 1.8       | 2.41      | 2.54      | 2.54   |
| Average LOS (hrs)                       | 74.84            | 77.85     | 35        | 64.72     | 69.39     | 69.39  |
| Average age of women (yrs)              | 46.38            | 50.04     | 44.74     | 48.68     | 48.37     | 48.37  |
| Number with weight of uterus provided   | 19               | 22        | 4         | 16        | 52        | 52     |
| Average weight of uterus (g)            | 211.2            | 200.77    | 169.25    | 136.69    | 180.63    | 180.63 |
IN THE NEWS

Insurers Stop Paying for Care Linked to Errors
Wall Street Journal Jan 15th 2008

Health insurers are taking a new tack in a bid to improve patient safety and reduce health-care costs: refusing to pay—or let their patients be billed—for hospital errors. They are moving to ban payments for care resulting from serious errors, including operating on the wrong limb or giving a patient incompatible blood. The companies are following the lead of the federal Medicare program, which announced last summer that starting this October, it will no longer pay the extra cost of treating bed sores, falls and six other preventable injuries and infections that occur while a patient is in a hospital. The following year, it will add to the list hospital-acquired blood infections, blood clots in legs and lungs, and pneumonia contracted from a ventilator.

More: http://online.wsj.com/article SB120035439914089727.html

Google Personal Health Record Begins its Preseason at Cleveland Clinic

Google is prototyping a personal health record with a group of patients at Cleveland Clinic, according to the New York Times.

The Times reports that the clinic is beginning a short pilot project to link “the health information for some of its patients with Google personal health records.” According to the clinic’s chief information officer, patients can approve the transfer of lab results, for instance, to their personal health records on Google, making the data available electronically to physicians whom the patients may be seeing outside of Cleveland Clinic.

The pilot project will last 6 to 8 weeks and involve fewer than 10,000 patients. Google’s personal health record product will be “made widely available” after the project is completed, the company’s health team manager told the Times.


The Clinical Report returns

Following an eight-year gap, the RWH has again published a Clinical Report. We have had a regular report since 1952. This tradition has had only two breaks, and with the current report bridging this gap with data from 1999 to 2006 we have a continuous picture of the clinical activity at the Women’s for 66 years. An achievement not matched by many hospitals in Australia.

Reporting on our clinical data however is much more than of historical interest. There are some very good reasons to provide an overview of our clinical activities, outcomes and performance for our professional peers. Firstly, it is the right thing to do. Last year we received $130,745,000 from the public to provide a health service to the women and babies of Victoria. It is incumbent on us to describe how we spent that money. Secondly, unlike the Quality of Care Report (which serves other purposes) the Clinical Report is comprehensive, reporting on everything we do clinically. In many areas it also attempts to report on indications, outcomes and complications. There are gaps in the report in areas such as pathology and allied health but we will continue to evolve its scope.

The Clinical Report is the first time many clinical services looked at their activity in toto. How many laparoscopies did we do in 2006? (1317) What were the commonest indications? (diagnostic 309, sterilisation 235) Are we doing more or less? (less) The report is a form of internal clinical audit that allows staff to reflect critically on clinical performance and identify areas to improve performance. People speak about the opportunities to benchmark clinical performance on the basis of a Clinical Report. These opportunities are limited as the lack of standard definitions and data collection systems between hospitals restricts accurate comparisons but many comparisons are possible. Furthermore, trend data allows us to compare ourselves to our previous performance. Why are we doing less laparoscopies when our activity is increasing? (our complexity has increased).

The Clinical Report also allows us to identify what we don’t know and would like to. It identifies gaps in our clinical data. For instance, new surgical procedures are used prior to their being given an ICD-10 code. By using data for relevant and useful reports the collection of data and its entry is improved. There is no code for total laparoscopic hysterectomy. We will undertake an extensive consultation on what we want in our next report and see what data collection systems are needed. In the meantime, let us know what you think about the 2007 RWH Clinical Report.

– Leslie Reti
Planning for the clinical relocation of maternity services has now advanced to the ‘per hour’ detailed stage for the three days of the move. This progress is quite a feat given the exceptional change environment in maternity services. It is a credit to the managers and team leaders, especially those on the Departmental Working Group, or DWG, who are balancing many priorities.

The focus of the plan is the safety and needs of the women and babies, minimizing disruption at the critical times of birthing and the early postnatal period. A key strategy is to have processes such as supported early discharge and additional DOM visits in place from the week prior to the move, thus reducing risk and the number of patient relocations from Carlton to Parkville. Where postnatal women and babies are to be relocated, they will travel together via ambulance. Where babies in NICU or SCN are relocating, their mothers will move to Parkville around the same time.

Clinical needs and emergencies are also considered, including consideration of family wishes if a baby dies, both timing and place of emergency caesarean sections and inductions, access to CTG and ultrasound. One of the identified significant risks is if a clinically unstable woman in advanced labour arrives at Carlton in the moments prior to closing clinical care at Carlton.

... if a clinically unstable woman in advanced labour arrives at Carlton in the moments prior to closing clinical care

Antenatal women who cannot be discharged may be offered day leave when clinically safe. They could have lunch at home and return to hospital at Parkville. Women who give birth at Carlton on the move day will be assessed for transfer to Parkville from birth suite rather than be transferred twice, to the postnatal ward and then on to Parkville.

Given the recent birth rate the greatest risk may be another weekend of extraordinary demand. This would impact on the careful plans to systematically consolidate the clinical inpatient areas in the 24 hours leading up to the ambulance transfers.

As transfers will only occur in daylight and the move is in winter, the plan has allowed for some women and staff to remain at Carlton for an additional night should demand create the need. The DWG was keen to prevent feelings of vulnerability in women and staff remaining at Carlton, and written into the plan are minimum staffing levels and security requirements.

We are now moving to the next phase of considering medical, midwifery, and clerical staffing numbers for each shift during the clinical move days. This means predicting how many staff will be required in each of the service areas at both sites, taking into account emergencies and risk factors. As the plan develops we revisit and identify risk.

If you would like information about the maternity move plan please contact Kaye Dyson or Veronica Love.

– Veronica Love
Chair, Maternity Departmental Working Group
The Quality and Safety Committee has been asked to consider the criteria for using mobile phones and similar devices within highly instrumental areas such as neonatal care units, high dependency areas such as birth suites, diagnostic imaging rooms, theatres and the emergency department. Current advice is that all such devices should be turned off when carried in these areas. However managers and clinicians, especially medical practitioners, often have a mobile phone or similar device with them for contact with patients and on-call services, for reference to Clinical Practice Guidelines, and sometimes these devices act as pagers. What advice should we be giving our clinicians and managers?

A variety of mobile electronic devices emit electromagnetic energy which has the potential to interfere with electronic medical equipment. These devices include mobile telephones, cordless telephones, radio transceivers, two-way pagers, and wireless PDAs. Whilst it can be argued that the spread of these devices has had many positive effects, some potential remains for interference with sensitive medical equipment and certain restrictions on their usage need to be considered. Improvements in the design of digital mobile technology and medical equipment mean that there is no need for hospital policies to be as conservative as they have been in the past.

“no need for hospital policies to be as conservative as they have been in the past”

The Quality and Safety Committee is satisfied that mobile phones and similar devices may be used without concern about the effects of interference in public areas of the hospital and in patient areas where there is no highly instrumental clinical equipment being used. Examples of such areas are staff offices, the main entrance foyer, lift lobbies, waiting rooms and the main corridors. Where an ambulatory patient is using an infusion pump and wants to leave the bedside area, consideration must be given to the risks associated with moving to areas where mobile phones are in use. Cordless telephones are low power transmitting devices and unlikely to interfere with medical equipment. These may be used in patient care areas.

Currently at the Women’s there is ample signage in public areas about not using mobile phones. In light of the relocation to the new hospital, no change to the signage will occur but the new hospital signage will reflect the current advice about mobile phones in public and non-instrumental clinical areas. The Quality and Safety Committee has asked the Biomedical Engineering department to provide more information by March 2008 about the emission of electromagnetic energy from mobile electronic devices in highly instrumented clinical areas. They have been asked also to make some assessment of the risk to patient safety with the use of these devices by clinicians in these areas. To date we have had no recorded incidents associated with emission of electromagnetic energy from mobile electronic devices leading to patient safety incidents. In the meantime, it is recommended that staff, patients and visitors who are in contact with a patient maintain a distance of at least one metre and preferably more from medical equipment when using a cell phone. This means that a staff member should not be talking on a mobile phone in an intensive care area, beside the bed of a patient, or adjusting equipment relating to that patient.

– Robert Barnett
Manager Biomedical Engineering
– Therese Caine
Coordinator, Quality and Accreditation

1 Wireless Communication Devices and Electromagnetic Interference: ECFP’s Updated Recommendations. Health Devices 300(11), Nov 2006, pp 449-456
2 Mobile phones in hospitals not as hazardous as believed. Editorial. BMJ 2003;326:460-461
Recently, The Royal Women’s Hospital and Royal Melbourne Hospital breast services merged to create The Breast Service in an attempt to create a centre of excellence for breast services in Victoria. Relocating next to the Royal Melbourne Hospital will enhance the ability to effectively implement coordinated and integrated psychosocial care within a single service across two sites. Currently, a large proportion of the psychosocial care coordination is managed by Breast Care Nurses. Other health professionals also play a vital role in assessing and managing the psychosocial needs of women diagnosed with breast cancer. The referral pathway to other health professionals and support services has been found to be inconsistent which has been shown to lead to some women receiving too much or too little support. Another component of the timely and effective delivery of psychosocial care is appropriate staff education on service availability, communication skills and referral procedures. In this case it is important to acknowledge the information requirements for clinical staff to enhance their ability to detect indicators of distress and/or anxiety to make appropriate referrals. Input from consumers can inform the current psychosocial model of care so that service provision more accurately meets their needs. Moreover, validation of consumer identified timelines of psychosocial care needs is also required to adequately inform the project and enhance project outcomes. Finally, the evidence-based foundation for psychosocial care is essential in building a psychosocial model of care that satisfies both staff and patients.

“building a psychosocial model of care that satisfies both staff and patients”

The aim of the psychosocial model of care project was to develop, implement and evaluate and where applicable alter The Breast Service’s current multidisciplinary psychosocial care model. An assessment of psychosocial distress is applicable to all women diagnosed with breast cancer, and includes both rural and urban women and those from different socio-economic, culturally and linguistically diverse backgrounds. Consequently, psychosocial care has been identified as a key area where The Breast Service can improve its quality of care.

The objectives of the Psychosocial Model of Care Project were to:

1. provide a brief literature review of the psychosocial issues faced by women diagnosed with breast cancer, the risk factors associated with psychosocial distress, the support services and programs developed to assist women with breast cancer and the NHMRC clinical practice guidelines for the psychosocial care of adults with cancer
2. provide an accurate reflection of the current psychosocial model of care from relevant professional stakeholders
3. provide an updated and accurate reflection from consumers regarding:
   a. their psychosocial needs
   b. the level of psychosocial support they received from the Breast Service
   c. how the psychosocial support assisted them with coping with breast cancer
   d. whether women felt comfortable discussing their psychosocial needs with members from The Breast Service
   e. whether there was any psychosocial support they would have liked to receive and did not, including issues or barriers to support service uptake
   f. their opinions on the structure and delivery of the current psychosocial model of care from The Breast Service. This includes feedback on the delivery of the psychosocial assessment tool (applicability and timeliness)
4. evaluation of the use of the Supportive Care Tool (SCT) (psychosocial screening tool), a review of referrals, service usage and documentation procedures
5. clear identification of issues based on consumer and health professionals’ reports and patient file audit
6. recommendations and/or revisions to the current psychosocial model of care including suggested prioritisation of findings.

The main themes from the professional stakeholder consultation identified were in relation to methods and procedures for assessing psychosocial distress, making referrals and delivering effective psychosocial supports. The results from the staff
Step 1  Identify high risk factors.  
**FIRST SUITABLE VISIT**

The revised assessment tool will allow breast care nurses (BCN) to document patient risk factors.

**Risk Factor checklist.**

Is/has the patient:

- Younger, Single, separated, divorced, widowed, Living alone
- Children younger than 21 years
- Experiencing economic adversity, A real or perceived lack of social support
- Poor marital or family functioning
- Had a history of psychiatric problems
- Had stressful life events
- Had a history of alcohol and/or substance abuse
- Just been diagnosed recently with cancer
- In the advanced stages of the disease
- Received a poor prognosis
- Having/had treatment side effects greater than most
- Experiencing lymphoedema
- Experiencing chronic pain and/or having difficulties managing pain
- Significantly fatigued

Step 2  Assess level of distress.

Does the patient appear or is the patient highly distressed/anxious?

BCN to distribute ‘distress thermometer’ whereby patients will rank their perceived level of distress from 0 (no distress) to 10 (extreme distress).

Step 3  Assess specific psychosocial concerns

BCN will distribute psychosocial checklist to patients where they can indicate (yes/no) whether they have experienced psychosocial distress on a range of dimensions (e.g. depression, anxiety, body image, sexual health etc)

Step 4  Psychosocial Assessment/interview with BCN.

BCN expands on relevant areas identified by patient in the screening process (distress thermometer and checklist) and records outcome on the screening forms.

**Patient is not considered high risk and is not distressed**

**Patient is considered high risk and is distressed and requires action (not immediate)**

**Patient is considered high risk and is distressed and requires urgent/immediate action**

Step 5  Psychosocial Multidisciplinary Meeting (PMDM) without SCT

Discuss Patient’s risk factors, assessment of distress, BCN evaluation and checklist responses. Multidisciplinary referrals are made where applicable, referral outcomes are discussed.

Step 6  Psychosocial screening conducted at:

1. Notification of diagnosis
2. Post-surgery check-up
3. During Chemotherapy
4. At the end of treatment

Go to step 2.

The Breast Service is an ongoing work in progress. The findings from the project have facilitated several changes to the assessment and delivery of psychosocial care by The Breast Service to women experiencing breast cancer. Moreover, the results from the staff consultations were used to inform a series of interviews and focus groups with women with breast cancer.

1. Based on the results of The Young Women’s Project (Breast Service Enhancement Program (BSEP))
2. Psychosocial model of care refers to the way psychosocial services are provided to the patient at The Breast Service. This includes the use of the Supportive Care Tool. For the current project, Psychosocial care refers to a response from clinicians to all aspects of practical, emotional and psychological coping from diagnosis of breast cancer, through active treatments (i.e. chemotherapy) and post-treatments (i.e. palliative care or adjustment to survivorship).

Overview of The Breast Service Psychosocial Model of Care
Managing medicines safely

One of the high risk areas in hospital practice relates to the use of medicines. In the management of medicines, there are many areas where an error or misadventure can occur.

During the dispensing process, medicine selection errors have been identified as one of the recurring errors reported. This has been greatly reduced or eliminated by having a mandatory scanning process as a final checking dispensing procedure.

Dispensing steps in pharmacy:
1. Check patient details, Medicare card, concession card
2. Prescription check – items required, interactions, restrictions, doses etc
3. Computer input – check against patient medicine profile in system. Enter the medicines required with the relevant directions and consumer information. (CMI)
4. Drug selection – select the prescribed items from the stock shelves
5. Labelling – label the containers with the medicine details and quantity ordered, directions, patient’s details and dispensing details
6. Label scan check – to ensure correct selection of medicine
7. Assemble prescription and check scan – collate the items required for the prescription in a designated box with handouts and CMI, then scan to match patient and prescription and profile check.
8. Verify correct person and final check with counseling – issue medicine to the correct patient – check allergies, sensitivities and ensure the patient understands how to take the medicines and what they are for.

The names of medicines when not written clearly or given verbally contribute to medicine misadventures.

Some similar names or commonly confused medicine names:

<table>
<thead>
<tr>
<th>Drug Name 1</th>
<th>Drug Name 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asacet</td>
<td>Adamet</td>
</tr>
<tr>
<td>Amifoxine</td>
<td>Alphamox</td>
</tr>
<tr>
<td>Betamethasone</td>
<td>Beclomethasone</td>
</tr>
<tr>
<td>Depran</td>
<td>Endep</td>
</tr>
<tr>
<td>Doxepin</td>
<td>Dophepin</td>
</tr>
<tr>
<td>Lamictal</td>
<td>Lamil</td>
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<tr>
<td>Lamictal</td>
<td>Largactil</td>
</tr>
<tr>
<td>Lasix</td>
<td>Losec</td>
</tr>
<tr>
<td>Muxicon</td>
<td>Moxacin</td>
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<td>Quineine</td>
<td>Quindine</td>
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<tr>
<td>Sertevent</td>
<td>Sertide</td>
</tr>
<tr>
<td>Tamoxifen</td>
<td>Tenoxiam</td>
</tr>
<tr>
<td>Zantac</td>
<td>Zyrtec</td>
</tr>
<tr>
<td>Zocor</td>
<td>Zoten</td>
</tr>
</tbody>
</table>

Reported medicines related incidents from Australian hospitals:

- Heparin sodium given instead of heparinised saline. This occurred on two occasions to the same patient in ICU
- Error in addition of potassium to IV infusion – wherever possible use premixed potassium solutions. At RWH we have the potassium 30mmol in a litre of normal saline or potassium 30mmol in a litre of Hartman’s solution.
- 1000 fold overdose due to confusion between microgram and milligram
- IV drug infused over 4 hours instead of 4 days
- Using unapproved abbreviations eg OD to mean daily – misread as BD and given twice a day. Units written as U and read as an extra zero. Write clearly in full and use only the approved abbreviations.
- Dose omissions
- Duplicated dosing due to omission of documentation

Some risk management tactics to keep in mind:

- Beware of interruptions, phone calls and distractions
- Fill only one prescription at a time
- Contact prescriber to remove all uncertainty
- Have checks in place in the processes
- Work standard hours and take breaks

We need to achieve a learning culture in our organization where all staff are encouraged to seek and learn about patient safety and information about risks and errors. All incidents and near misses are to be reported.

To make significant safety improvements and to remain consistently mindful of patient safety we have to be aware of these incidents from within the organization and externally. These are to be communicated to all staff so that we are always thinking critically about patient safety.

– Swee Wong