

26 October 2007

Ron Paterson  
Health and Disability Commissioner  
PO Box 1791  
**AUCKLAND**

Dear Mr Paterson

Thank you for the welcome opportunity to correct any factual errors and respond to areas of concern prior to the release of your general findings into the "safe guards that are in place to prevent a similar event occurring (as occurred in the CCDHB case)". The DHB has also provided responses to the items raised in the BOPDHB specific report from your expert Dr. Seddon. Both documents are attached.

The DHB has implemented a number of systems and processes in order to mitigate risk, but we remain cognisant that when complex multi systems are involved, such as in the CCDHB case, adverse events may still occur and staff need to be continually provided with tools and reinforcement on appropriate ways to deal with such situations.

Contained within the attached responses is confirmation of the following as they relate to issues raised by the reviewer:

- Both Tauranga and Whakatane Hospitals have HDU beds within their ICU/CCU complex. Tauranga is a Level 2 ANZICS ICU and Whakatane a Level 1 ANZICS ICU.
- A Modified Early Warning System (MEWS) has been implemented in the acute surgical and medical units at Tauranga Hospital and is currently being evaluated.
- Clarification is provided in relation to the evaluation of a hospitalist role.
- The timely review of x-rays will be enhanced by the implementation of a new PACS / RIS system. This is a joint project with Waikato DHB, and the implementation will be simultaneous at both DHBs. Final negotiations are underway with a preferred provider and a phased roll out will commence in 2008.
- Radiology reports and laboratory results are readily available (and have been for some time) electronically on the Clinical Intranet System, and this provides backup should radiology films be unavailable.

To clarify the reference to Dr Jeff Garrett, it should be noted that it was initially agreed by the Medical Department that Dr. Garrett would be approached for advice regarding handover issues. However, Dr Garrett was out of the country when contact was attempted. At a subsequent meeting of the BOP Medical specialists it was felt that they wished to have further time to develop their own handover policies and therefore Dr. Garrett's involvement was not actively followed up. Because of the comment in the reviewers report, Dr Jeff Garrett has been contacted and advised that the DHB is undertaking a Medical Department review with one of the key Terms of Reference being patient handover.

Once again, the BOPDHB thank you for the opportunity to provide clarification and should there be any further information required, please do not hesitate to contact me.

Yours sincerely

**PHIL CAMMISH**  
Chief Executive

Cc Graham Dyer, Chief Operating Officer, BOPDHB

## ***Response to HDC re Report of Overview of Responses from the DHBs***

BOPDHB provides the following response to the report of Overview of Responses from all the DHBs:

1. Identification and management of the deteriorating patient – A Modified Early Warning System (MEWS) has been implemented across the acute medical and surgical units in Tauranga Hospital.

The initial implementation was in the Tauranga Medical Admission and Planning Unit (MAPU) and formal evaluation through audit is currently in progress.

The tool is to be implemented in Whakatane Medical and Surgical wards in November.

2. Provision of High Dependency Care – For further clarity BOPDHB does have HDU beds available at both Whakatane and Tauranga Hospitals. HDU beds are assigned within the ICU/CCU complex at both hospitals. Patients in these beds are managed by their assigned specialist. Should the patient's condition deteriorate, they will be referred to an ICU with the appropriate level of support
3. Timely review of X-rays - with respect to the development of digital radiology, BOPDHB is in partnership with Waikato DHB to introduce this technology to all its hospital facilities. A preferred provider has been selected and negotiations are underway. Once agreement has been reached with the preferred provider, a phased roll out of PACS / RIS will commence in 2008.

In addition to this, x-ray results are available through the existing Clinical Information System. Should x-ray films be unavailable, the reports from the films remain available to the clinicians on the wards electronically through the Clinical Intranet

## ***Review of Bay of Plenty DHB response to HDC***

It was an oversight that BOPDHB did not respond to issues other than the recommendations from CCDHB's own internal investigation Appendix 1.

As confirmed in the recent Ministry of Health certification surveillance report, clinical and safety issues are identified through risk management assessment processes and recorded in the risk register if assessed to be a risk.

BOPDHB has implemented a number of systems and processes in order to mitigate risk, however, when complex multi systems are involved such as in the CCDHB case, an adverse event is a risk that can never be fully eliminated. Where risks cannot be removed, measures are adopted to either mitigate them or minimise their impact.

In relation to the issues that Dr Seddon notes, the following additional information describes the safeguards in place to prevent a similar event occurring at BOPDHB.

### ***Issues Identified by BOPDHB:***

#### ***1. Communication***

- (i) **Nursing** - There is a planned audit of the revised care plans to be completed 31 October 2007. The Admission to Discharge Planner has the discharge planning section front and back which is for all disciplines.

For clarification regarding the shredding of handover notes, these are a summary taken directly from the patient's health record and it is the health record which contains the permanent record of information.

- (ii) **Medical Handover** – The handover process has significantly changed, reflecting the emphasis placed on this activity post the CCDHB incident. A Medical Department review has been initiated and enclosed are the Terms of Reference for this. A new handover process is in place in the Medical Department and this has been introduced ahead of the review's completion. As staff change, the importance of reinforcing this process to new staff is recognised and it is expected that the medical department review will provide an opportunity to audit the degree to which this process is now adhered to.

**Process to evaluate the appropriateness of the employment of hospitalists** – Dr. Neil Graham, Medical Leader, Medical Services, feels that the physicians do not regard themselves as hospitalists, in agreement with what Dr Seddon states. There is a trial underway in NSW utilising hospitalists which has been initiated due to limited resources and is designed to ensure that patients do not fall between specialties and to ensure that there is good communication with the primary sector. BOPDHB is only in a preliminary stage of investigating the hospitalist model, however it was noted in our initial response to give recognition to possible future staffing constraints and to show innovative ways to ensure that the Capital and Coast Health problems do not occur in the BOPDHB. Enclosed is a copy of a relevant PowerPoint presentation.

## 2. Knowledge, skills and competency

- (i) **MEWS** - A modified early warning system (MEWS) has been implemented across the acute medical and surgical units in Tauranga Hospital. Full implementation will be completed in November across Whakatane Medical and Surgical wards. Interestingly, the case study used to illustrate the application of MEWS at the education sessions was a patient with severe respiratory illness.

Sandra Fielding (Nurse Leader, Medical Services BOPDHB) and the Nurse Educators who implemented the BoP MEWS system discussed EWS with Alison Pirret, (Middlemore ICU Nurse Practitioner) and were guided by her advice.

The CCDHB case has been discussed at both night staff in-service for nurses and the nursing lunchtime in-service. The full case was also discussed at the Professional Nursing Forum which covers both sites, to assist with review of systems and processes in relation to the report.

- (ii) **Education of medical staff need for timely Xray review** –The introduction of the PACS / RIS system has been approved by the Board and is fully budgeted. The project is a joint BOPDHB / Waikato DHB implementation and will link the Waikato DHB hospitals with Tauranga and Whakatane. Dr Graham has confirmed that the standard process of reviewing xrays on a post acute round is that xrays are always present, however, it is recognised that xrays could be unavailable, especially in the non-acute situation. Radiology reports and laboratory results are already available through the Clinical Intranet and all SMO's have been educated in retrieving reports. This provides back up should the x-ray film be unavailable.

## 3. Work environment/scheduling

**HDU** - The Bay of Plenty District Health Board has HDU beds assigned within the ICU/CCU complex at both hospitals. Patients in these beds are managed by attending Clinicians.

Whakatane Hospital has a shared CCU and HDU and patients are under the care of attending Clinicians. Tauranga Hospital has HDU beds assigned within the ICU and patients in them are cared for by attending Clinicians. Intensive Care Specialists are available in Tauranga to manage the critically ill. Critically ill patients in Whakatane are transferred to ICU facilities at either Waikato or Tauranga dependent on their clinical situation.

With respect to the confusion around BOPDHB HDUs, there are no plans to have a separate HDU at either Tauranga or Whakatane and the current arrangements as outlined, are to continue.

## 4. Patient factors

- (i) The Smoke Free Policy and associated protocols which were under review at the time of collating the report have now been updated and authorised by the Executive. The Smokefree Co-ordinator has developed an implementation plan with education to accompany the revised policy and protocols. The protocols contain an assessment tool.

- (ii) Both gums and patches are available during and after hours. At this stage a standing order has not been considered. If issues are raised around access and availability, this would be considered. An audit will be completed once the revised policy and protocols have been in place for three months.

***Issues not addressed or discussed by BOPDHB:***

1. **Open disclosure** – BOPDHB does not have a specific open disclosure policy, however it is practice for all events, whether they are sentinel or not to have a completed reportable event form (attached). This has a section regarding patient and family being informed. Where this is not done, BOPDHB requires explanation from staff. There have been a number of specific courses offered to staff which incorporate principles of open disclosure. During orientation and in house training, the philosophy of open disclosure is promoted.
2. **Referrals to the coroner** – There is a Notification of Death policy and this is currently under review. In addition, consideration is now being given to the setting up of a mortality review group to discuss all deaths to enhance the service level reviews currently carried out. Within the Notification of Death Policy, there are criteria for notifying the coroner.

Communication with the Coroner does occur where policy requires. Within the last few years BOPDHB has stopped automatically providing the Coroner with copies of sentinel event reports, however these are made available where requested. As a result of this review, the Medical Director has made contact with the Coroner with the aim of promoting effective two way communication. The Coroner will address the Medical staff in November.

3. **Timely review of laboratory results** – The BOPDHB has electronic reporting of results to ensure that paper results are not lost. The electronic reporting includes a requirement to sign off results and provides for the automatic escalation of abnormal results. Training is provided to to keep the Clinicians up to date with system developments.
4. **Serious adverse events** – BOPDHBs sentinel event policy requires the family to be notified within the first 48 hour period.

BOPDHB has staff who are specifically trained in root-cause analysis and sentinel event processes. Each service has a Quality Co-ordinator (QC) assigned, eight QCs in total. QCs assist those conducting incident investigations at service level, providing support and guidance. Where an incident is more serious or sentinel, the Quality Manager or Quality Team Leader co-ordinates the process and provides training and guidance on root cause analysis etc to team members. The process is standardised and follows that of the sentinel event workbook SNZ HB 8152:2001 including the use of the action plan (pg 21). Root cause analysis is undertaken using the New South Wales process. Where required, staff are given training on quality tools, although it is not included in the formal in house training programme.

Where the event is considered to be a sentinel one the CEO is automatically notified.

5. **Care of the marginalised patient** - It is recognised that the best place to identify and develop treatment care plans for the marginalised patient is in the admission phase. We recognise that the marginalised patient has complex psychosocial and physical needs and is therefore at greater risk. We are mitigating this risk by ensuring early identification of these patients and involving appropriate Multi Disciplinary Team input, particularly at the Medical Admission Planning Unit stage. Additionally BOPDHB is ensuring staff are supported in the education processes. The Clinical Governance philosophy supports a patient centred approach to care and Customer Service training is available to all staff.