



*Auckland District Health Board
Chief Executive's Office
Level 1 Building 10
Greenlane Clinical Centre
Phone: 09 630 9943
Internal Ext: 4402
Fax: 09 638 0347
Email: garrys@adhb.govt.nz*

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Ron Paterson
Health and Disability Commissioner
P O Box 1791
AUCKLAND

Dear Ron

Re: ADHB response to HDC feedback: additional information/comments

I write in reply to your letter of 15 October requesting a response to above.

Re: ADHB's overall response.

It was commented that there was no mention of the HDC report being discussed at clinical or managerial forums. However, the HDC report was discussed extensively within the ADHB:

- Clinical Board
- Nursing forums including: Nursing Practice and Quality Council, Nursing and Midwifery Leadership group; and a specially convened nursing grand round where Cheyne Chalmers, DoN for Capital & Coast DHB spoke.
- CD meetings
- Clinical Partnership meetings

Many SMOs and senior nurses took part in the organisational wide stock-take to identify shortcomings in our patient safety systems.

Re: ADHB response to physiologic deterioration

The teams responding to Codes Red (adults) and Pink (paediatrics) are multidisciplinary, involving medical and nursing staff. These code calls form a clinical indicator that is reported quarterly to clinical board.

The ADHB is considering a "staged escalation response" (an Early Warning Score) and its work is based, in part, on the NICE clinical guidance for the "management of the acutely ill adult in hospital". Dr Bridie Kent was part of the review team for the NICE guideline and so is familiar with its content.

An EWS system will form part of the After Hours model of care, due for piloting early 2008, using an 'i-bleep' system. This is also based on UK innovations. The resuscitation committee and clinical board are also involved in the development of an EWS system

Re: Clinical leadership/oversight/nursing clinical support/scope of practice

The ICU outreach is under-developed, partly because outreach remains unproven in effectiveness but also for the reason that the Clinical Nurse Advisers currently provide expert support (almost all of whom previously worked in critical care settings). The ICU remains a further resource for advice, support and guidance.

The Clinical Board and CMO are leading the development of Code of Practice to promote “*more consistent senior medical supervision in acute clinical care.*” This Code is scheduled to be completed by December 2007. The After Hours Project will also enhance senior leadership and supervision as approaches to senior medical support are included in the plan. Clinical Board (of which the CMO is chair) intends to monitor both projects to ensure their successful implementation and uptake.

Re: Staffing numbers/sick leave/skill mix

The RMO shortages are high on the ADHB’s agenda and the deputy CMO has been assigned to actively engage ADHB in seeking a resolution to this problem. Nurse-facilitated initiatives for the less complex patients have also been instigated. These include limited discharges of certain patients, through the use of guidelines and advanced nursing knowledge, in APU, cardiac, ORL and other services.

Re: Availability and review of x-rays and blood tests

Different departments have very different needs in acute radiology ranging from bedside clinicians acting on transient images on intensifiers or acting on unreported films, to discussion directly with acute radiology service, and interventional requests in the acute situation. Access to images, lab tests and reporting is excellent.

Reconciliation of radiology reports in less acute and elective situations is a current \$700K IT project due to deliver its first pilot in April ’08. This will inform our approach to lab tests reconciliation which currently is the traditional “clinician pool” system that has some limitations in some situations.

Re: Handover

Ensuring continued improvement in handover practices is one of the objectives of the Nursing Practice and Quality Council for 2008. Interdepartmental handover has improved due to standardised documentation based on the handover policy. This remains an ongoing issue due to staff turnover. The Clinical Board are also engaged to ensure that all opportunities are taken to improve the quality and consistency of handover in all parts of the organisation.

New systems are being introduced that should assist the development of electronic recording of nursing handover. This initiative will be led by the Nursing Leadership group.

Comments on medical handover are not restricted to general medical handover and Emergency Care handover. The term ‘Medical’ used here includes medicine and surgery.

There were no specific references to the work on handover by the Australians and the British. This was not specifically requested in the response. However, the initiatives being implemented are largely based on UK work, including Hospital at Night, which we have called ‘After Hours project’.

Re: Management of Smoking addiction

A patient’s smoking status is documented on admission and smoking behaviour is recorded in the admission to discharge planner. This process for this is clearly outlined in the Nicotine Dependent Patient guidelines for management.

It is intended that NRT suitability will be assessed by the admitting doctor and therapy prescribed with various encouragements to raise compliance. Stocks of patches, gum and combination therapy are available on all wards. Standing orders are not being considered due to the complexity of most patients in ADHB.

Re: Open Disclosure

Hospital surveyors have commented on the good staff awareness of our organisational values. This is because they are promoted throughout the organisation from the CEO down, and their use encouraged as a yardstick to measure actions against. Thus we think that promoting the

organisational value “integrity” we are open honest and transparent in everything we do: this we feel is better than a policy.

This has been widely discussed at Clinical Board and the ADHB is committed to promoting open disclosure principles within the organisation. Current practices are currently being reviewed to achieve alignment with the Open Disclosure model that operates in the mental health services. Nursing has this as the key focus for Nursing Grand Round in November. A consumer liaison department has also been formed to ensure closer communication with service users. A recent example of CJD exposure illustrates our approach.

Re: Review Processes

Clarification was requested for some points. The RCAs are conducted by a clinical team, which involves clinical specialists and quality advisors but it would not include individuals involved in the event.

At ADHB, we do communicate with the patient and/or family about the investigations.

The RCA reports are all forwarded to the Level 1 partnership, which at ADHB includes the CE, CMO, Executive Director of Nursing and Director of Allied Health. The report also goes to Clinical Board.

ADHB has put in place a number of patient safety/quality initiatives, and a working group (from Clinical Board) to oversee the process. Not all the recommendations or actions will be completed within 6 months but we can provide an update on progress to you if you wish.

Yours sincerely

Garry R Smith
Chief Executive