



Learning from mistakes — a nationwide patient safety initiative

HDC recently published Dr Mary Seddon's review, "Safety of Patients in New Zealand Hospitals: A Progress Report", in light of responses by all 21 DHBs to HDC's Capital and Coast DHB inquiry report. Dr Mary Seddon's review is summarised below.

Understanding a safety culture

Dr Seddon noted that the literature over the last 10 years identifies the practice of medicine as a complex adaptive system, that humans make errors, and that a safe system predicts errors and sets up defence systems to prevent errors impacting on the patient. She commented: "The DHBs seemed to fall into one of three categories: those that really understood what a safety culture was and demonstrated systems thinking; those that superficially used the language of safe and quality care, but their action plans did not give confidence; and those that have not really moved on from the individual blaming culture — they continue to believe that if doctors just concentrated harder, worked harder and were more careful, that medical errors would not occur."

Dr Seddon noted that although almost all DHBs produced an abundance of policies, adherence to those policies is rarely audited. Having a written policy was not an end in itself — policies need to be supported by educational programmes to ensure their proper implementation, and compliance with policies needs to be audited.

Areas for improvement

The 10 areas for improvement most frequently identified by the DHBs were:

Identification and management of the deteriorating patient

Several DHBs already utilise "Track and trigger" systems where scores are used to identify a patient's physiological state and help staff escalate care appropriately. Such systems are more sensitive to early deterioration and are less dependent on staff knowing what to do, than single criteria systems.

Provision of high dependency care

Physiologically unstable or deteriorating patients may need increased nursing and medical care. However, some hospitals do not have, or see the need for, areas/units with more intensive nursing support.

Handover of care

Good handover is essential on nursing shift changes, between either junior or senior medical staff, and between nurses and medical staff. Handover practices were variable, generally verbal and not standardised in any way. Several DHBs are instituting formalised handover. It is important that such communication is clear, concise and in a format that makes sense to the person receiving the information.

Timely review of X-rays

Many DHBs have a fully manual radiology service, which usually works but becomes a problem if X-rays go missing and when there is no way of knowing who has viewed them. Digital radiology allows a clinician to view X-rays from any hospital computer and, at its fullest application, also records all staff who view results and allows electronic acceptance of radiology reports. Two smaller DHBs and several large DHBs have this technology. However, few DHBs have an audit of timely sign-off of results.

Investigation of sentinel events and communication with the Coroner

Dr Seddon commented that although nearly all DHBs had or are developing a Sentinel Events policy, most DHBs considered a policy to be an end in itself. Some DHBs have Sentinel Events Review Panels, but no DHB described a training programme on how to investigate or respond to a serious or sentinel event.

Relationships with the Coroner varied as regards formality and existence of processes to facilitate appropriate communication in the case of a hospital death.

Open disclosure policy and practice

Open disclosure means keeping patients and their families informed, both when something goes wrong, and when the results of sentinel events investigations are known. Many DHBs have components of open disclosure embedded within their sentinel events policy, but none has put any emphasis into training staff in the philosophy and practice of open disclosure.

Management of the nicotine-addicted patient

Although all DHBs have a smoke-free policy in line with legislation, they vary widely in their response to the nicotine-addicted patient — whether taking the perspective of treatment for acute nicotine withdrawal or getting the patient to quit smoking. The process for identifying which patients are likely to withdraw from nicotine is not well developed in most hospitals.

Scope of practice for Enrolled Nurses

DHBs have responded to the Wellington case by identifying the problem with the nursing care as a lack of ability on the part of the Enrolled Nurse (EN), or a lack of supervision of the Registered Nurse (RN), and introduced policies accordingly. Yet Dr Seddon noted that the key issue was a lack of understanding of the importance of taking regular observations and knowing how to interpret any deviation from normal. Although defining scopes of practice of ENs is important, training and review of all staff who take vital signs (including Health Care Assistants) is perhaps more important.

Medical staffing

The absence of the admitting medical registrar from the post-acute ward round reflects the shortage of junior medical staff. This appears to be a concern to many DHBs and it appears unlikely that the shortage will be resolved in the short term.

Early assessment and planning in the Emergency Care department

Many DHBs have identified long stays in EC departments as a threat to patient safety. Several DHBs are progressing “patient flow” projects aimed at facilitating the journey of patients through EC to medical staff who can make decisions about admission and start effective treatment. An Acute Medical Assessment Unit helps make passage of EC patients more efficient.

Collaboration amongst DHBs

Dr Seddon highlighted examples of DHBs with good practices and policies that could be standardised across the country. She has also identified areas where national collaboration would hasten systematic improvements, including: development of Early Warning Scores, standardised sentinel event investigation training, national open disclosure policy and training, standardised initial communication process with the Coroner, and standardisation of handover processes.

Resolving complaints: New Zealand and Australian practices

As part of the six-monthly meeting of the New Zealand and Australian Health Commissioners held in Brisbane in October, a simultaneous meeting took place involving the Investigation and Assessment Managers from each Office. The purpose was to get to know each other, and to identify similarities and differences in the way each jurisdiction manages complaints.

An overall view suggests there are broad similarities. Each jurisdiction undertakes an initial assessment involving reading the complaint and identifying the issues. Information is obtained from the other involved parties, most often the provider. Where necessary, clinical advice is used to help form a view on the standard of care. A decision is then made about what action to take. Each jurisdiction has an “early resolution” function; the ability to take no further action if the care appears to have been reasonable; some form of investigatory power; a more formal alternative dispute resolution option, such as mediation; and the ability to refer a complaint to another agency where appropriate.

Further discussion, however, revealed a number of differences between each jurisdiction. Of particular relevance were the differences between the Australian Commissions and HDC. Primarily these differences are legislative. The Australian Commissions have set timeframes for considering older complaints. Complaints need to be made, for the most part, within two years of the event in question or they are “out of time”. HDC has no such time limit but can (and does) take into account when the events occurred, as part of the assessment process. The Australian Commissions are statutorily required to conduct their assessments and make a decision within a specified number of days. HDC is required to conduct a preliminary assessment “as soon as reasonably practicable”. HDC is the only jurisdiction that uses independent advocates to help resolve complaints.

All of the Australian jurisdictions have a conciliation option, which appears to be heavily used. This usually involves referring the complaint to an external conciliator who works with the parties to resolve the matter. Conciliation is a legally privileged process and the feedback from the various Australian complaints managers is that this appeals to providers. HDC does not have a formal conciliation option, mediation being the alternative dispute resolution option provided for in the HDC Act.

The other major difference is the relationships (some good and some bad) that the Australian Commissions have with the large medical indemnity insurers. Because of the ACC scheme, this is much less of a concern in New Zealand.

Beyond these legislative differences, most of the jurisdictions have a similar approach to managing complaints. The focus is on resolving concerns as speedily and as effectively as possible.

Consulting with Pacific Islands Peoples

In June and October 2007, HDC held two Pacific Peoples Consumer Seminars. The seminars were held in Otahuhu, South Auckland, and a total of 110 people attended. The purpose of the seminars was to introduce the role of the HDC, to find out how the HDC can be of better service to Pacific communities, and to hear participants' views on the quality of health and disability services.

Suggestions for HDC action

What we were told that HDC could do to provide a great service included:

- Informing and keeping in touch with Pacific communities by:
 - more regular use of Pacific radio stations, especially talkback radio
 - more face-to-face presentations/talks at churches by HDC staff
 - more regular meetings and contact with Pacific providers and community groups
 - more regular contact and communication with Pacific leaders
 - more regular contact via email with Pacific groups
 - presenting on *Tagata Pasefika* television programme.
- Recruiting more widely using Pacific networks to get more Pacific staff working in HDC in positions that have direct contact with Pacific consumers and service providers. This is to ensure Pacific people contacting HDC have access to people who speak Pacific languages and who understand the different Pacific cultures.
- Ensuring HDC staff and advocates respond in a timely manner to voicemail messages, and keep the use of automated telephone messages to a minimum, as people prefer to talk to a person.
- Establishing a specific body that is resourced to work with HDC in a meaningful way as advisors and as a communication link with Pacific communities.
- Running regular Pacific consumer seminars with feedback about action resulting from the information and

suggestions received. Making sure information advertising the seminars is distributed widely and that there is plenty of lead time into the seminars so as many people as possible can attend.

- Working more closely with existing community advocates, and with other agencies (eg, Housing New Zealand, Work and Income) so groups are working together in a supportive way.

What HDC is doing

- A 1–2 page email newsletter with information from HDC for Pacific communities will be distributed bi-monthly, starting in December 2007.
- A Pacific focused section will be placed on HDC's website with information for Pacific communities, starting from May 2008.
- All HDC job vacancies will be sent via email alert to all those on HDC's Pacific contact list from January 2008.
- A four-person Pacific Advisory Group will be established by February 2008 to be part of the Health and Disability Commissioner's Consumer Advisory Group.
- Two Pacific consumer seminars will be held annually, one in Auckland and one in Wellington.

The next Pacific Peoples Consumer Seminar will be held in June 2008. There will be details about the seminar on our website closer to the time.

Evaluation

We are seeking feedback from readers regarding the usefulness of the *HDC Panui* bulletins and would appreciate your response to a short survey.

The survey can be found on the HDC website www.hdc.org.nz listed under "What's New" on the left-hand side of the Homepage.

Thank you for your assistance.

We welcome feedback on *HDC Pānui*. Please send any comments about information you would find useful to Elizabeth Finn, Education Manager, at panui@hdc.org.nz. *HDC Pānui* is also available on www.hdc.org.nz.