Patient care and quality assurance systems
(Gisborne Hospital Report, March 2001)

Public hospital ~ Operating theatre protocols ~ Standard of care and co-
or-ordination ~ Quality assurance systems ~ Incident reporting and complaints
procedure ~ PSA testing procedures ~ Refusal of consent to anaesthesia ~
Rights 4(1), 4(2), 4(4), 4(5), 7(7), 10(6)

In June 2000, the New Zealand Nurses Organisation wrote to the Minister of Health
and contacted the media about concerns of nurses employed at a small, provincial
public hospital. The admitted re-use of syringes by a visiting anaesthetist and the
potential risk of disease transmission to 134 surgical patients were widely published.
In July 2000, the hospital announced that an error had been made by its laboratory in
carrying out prostate specific antigen (PSA) testing. One hundred and seventeen
patients were notified of the error and advised to see their general practitioner about
the need for re-testing. Against this background, the Commissioner initiated an
inquiry into patient care and quality assurance systems at the hospital. The subsequent
report found specific breaches of the Code in the operating theatre (due to the re-use
of syringes) and in the laboratory (due to failures of quality control and human error in
relation to PSA test results). The Commissioner also found breaches of the duties of
care and co-ordination by the hospital provider, due to the failure to have adequate
quality assurance and incident reporting systems in place. Quality and continuity of
patient care was potentially compromised by the lack of an effective incident reporting
system. The hospital’s complaints procedure did not inform patients of relevant
internal and external complaints procedures, in breach of Right 10(6) of the Code.

An anaesthetist inappropriately re-used syringes, failed to dispose of sharp
instruments in accordance with theatre protocol, and administered anaesthesia
(fentanyl) despite a patient’s specific refusal of consent. These acts by the anaesthetist
constituted breaches of Rights 4(4), 4(2) and 7(7) respectively.

The Commissioner’s report included 34 recommendations related to incident reporting
and complaints handling, recognising that analysis of adverse events in health care
should focus on root causes, and not simply the proximal events or human errors in
isolation of wider processes and systems. The Ministry of Health subsequently audited
the hospital and confirmed that the recommendations had been implemented. The
report was distributed widely and is being used by other public hospitals in New
Zealand to improve the quality of care.

Several general points are worthy of note. First, if reported incidents are not
investigated and reported back on, complainants feel disenfranchised and not valued,
and an environment of distrust and poor confidence will result. To prevent this, there
needs to be a culture of learning, not blame. Extending reporting to cover “near
misses” reflects a focus on prevention and improvement, rather than on finger-
pointing and recrimination; on teamwork, rather than individual culpability.

Secondly, care needs to be taken that any emphasis or focus given to a single safety or
accreditation issue does not undermine a general culture of safety and excellence.
Long-term goals and practices need to be protected from possible inadvertent harm
caused by pursuing short-term goals.

Thirdly, staffing levels should be sufficient not only to cover the daily workload but
also to allow staff to undergo continuing practical training sessions, attend regular
section meetings, attend user group meetings to discuss quality issues, keep
documentation and quality manuals up to date, and carry out any other activities that
contribute to improving and maintaining quality.