2 July 2015

Manager, Specialist Training and Program Assessment
Australian Medical Council
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AUSTRALIA

College of Intensive Care Medicine of Australia and New Zealand

I write further to Chief Executive Officer Ian Frank's letter of 22 May 2015 regarding the Australian Medical Council's assessment of the education, training and continuing professional development programs provided by the College of Intensive Care Medicine of Australia and New Zealand (CICM). To assist with this assessment, you are consulting with stakeholders about CICM training and design planning, training content, and training outcomes.

As Health and Disability Commissioner (HDC), I am charged with promoting and protecting the rights of health and disability services consumers in New Zealand, as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

One of my functions under the Health and Disability Commissioner Act 1994 (the HDC Act) is to make public statements in relation to any matter affecting the rights of health or disability services consumers. It is also one of my functions to investigate complaints alleging that the action of a health or disability services provider is, or appears to be, in breach of the Code. Following an investigation, I form an opinion on whether there has been a breach of the Code and make recommendations to providers to improve service delivery and care quality, at a provider, organisation, and sector level. Further information about the role and function of the HDC is available on our website: www.hdc.org.nz.

The HDC Act and Code occupy a prominent position in the medico-legal landscape and practice of medicine in New Zealand. I would expect that the training content of the CICM would cover aspects relevant to the practice of intensive care medicine in New Zealand, including, in particular, reference to the HDC Act and Code.

In addition, I draw your attention to a recent Opinion (12HDC01133, available on the HDC website) about the provision of intensive care to a consumer, which resulted in recommendations being made to improve the delivery of intensive care services. The case involved an elderly man admitted to hospital with a diagnosis of gallstone ileus. The man was referred for a laparotomy and removal of his gallstone. A preoperative chest X-ray showed evidence of likely aspiration pneumonitis, and it was arranged that the man would be admitted to the Intensive Care Unit (ICU) postoperatively. During handover to the ICU team after the man's surgery, the anaesthetic team advised that the man would require a postoperative chest X-ray. The chest X-ray was taken, but not reviewed by any member of clinical staff until over 24 hours later. During that time, the man continued to deteriorate and, he was subsequently commenced on palliative care and passed away the day after his surgery.

The Opinion found that staff failed to undertake a timely review of the man's postoperative chest X-ray, and the ICU team failed to consider differential diagnoses for the man. The Opinion also found that there were failures by staff to communicate adequately with each

other regarding the man's condition, which affected the quality and continuity of services he received.

The district health board (the DHB) carried out a Sentinel Event Review and made a number of changes to its service, including that clinicians are now able to review results from home, the implementation of a paper-based flag system to show that an X-ray has been taken, the implementation of a radiology review tick box system for clinicians to sign off once they have viewed an X-ray, the implementation of a system to automate reminders for reviewing films, and affirming current practice to take routine X-rays for all appropriate ICU patients each morning to be reviewed after the ward round. The HDC recommended follow up with the DHB on the implementation of the changes following the DHB's review, and further recommended that the DHB review its processes regarding handover of care between departments, and responsibilities for reviewing radiology.

Thank you for the opportunity to comment.