Annual Report on Protected Quality Assurance Activities

Organisation Name: Royal Australasian College of Surgeons

Reporting Period: 15 April 2013 – 14 April 2014

1. Name of Quality Assurance Activity

Australian and New Zealand Gastric and Oesophageal Surgical Association Audit (ANZGOSA Audit)

a) List any problems or issues that have been identified in the course of the activity:

Not applicable. The ANZGOSA Audit functions as a self-audit tool.

Once the audit has enough data to be representative of each region, the ANZGOSA Audit will be in a position to report on aggregate results and conduct research into treatment of oesophago-gastric cancer and gastro-intestinal stromal tumours. The newly implemented upload program will contribute to this goal. The program has now uploaded data from South Australia, which is current up to the end of 2013. The next uploads are expected to be from Victorian and Queensland.

b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

Not applicable.

c) List what recommendations have been (or are to be) made as a result of the activity:

Not applicable.
d) Describe how implementation of these recommendations will be monitored:

Not applicable.

e) Describe how any improvements to the practice or competence of your organisation, or any of your organisation’s agents or employees, are to be managed:

The ANZGOSA Audit functions as a self-audit tool. Individual participants are expected to use the audit to identify any issues with performance and initiate improvement.

The Institutional Upload Program went live in September. The program will upload data into the ANZGOSA Audit system from existing large databases which will allow surgeons who currently collect data into a different system to be able to access the quality assurance services of the ANZGOSA Audit without having to double-enter data into two systems. This will increase the reach of the ANZGOSA Audit throughout Australia and New Zealand.

f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

The College and ANZGOSA promote participation in the audit as a means of data collection and self-assessment of performance, with the ultimate aim of improving surgical care for patients with oesophago-gastric cancer or gastrointestinal stromal tumours in Australia and New Zealand.

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Ministry of Health
PO Box 5013
Wellington 6145
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Annual Report on Protected Quality Assurance Activities

<table>
<thead>
<tr>
<th>Organisation Name:</th>
<th>Australian and New Zealand College of Anaesthetists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Period:</td>
<td>28th August 2014 (Annual report)</td>
</tr>
</tbody>
</table>

1. Name of Quality Assurance Activity

Australian and New Zealand College of Anaesthetists (ANZCA)
Trainee Portfolio System – Cases and Procedures

a) List any problems or issues that have been identified in the course of the activity:

No issues to report for this period.

b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:


c) List what recommendations have been (or are to be) made as a result of the activity:


d) Describe how implementation of these recommendations will be monitored:


e) Describe how any improvements to the practice or competence of your organisation, or any of your organisation’s agents or employees, are to be managed:

ANZCA is committed to delivering a high quality training program that will contribute to improved care and quality outcomes for the community.


f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:


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Annual Report on Protected Quality Assurance Activities

<table>
<thead>
<tr>
<th>Organisation Name:</th>
<th>The Australian and New Zealand College of Anaesthetists</th>
</tr>
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<tbody>
<tr>
<td>Reporting Period:</td>
<td>31/3/13 – 31/3/14 Annual Report</td>
</tr>
</tbody>
</table>

1. Name of Quality Assurance Activity

The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC), Incident Recording and Reporting Project.

a) List any problems or issues that have been identified in the course of the activity:

The ANZTADC project was released in Australia in October 2010. Software updates have been made periodically. This is a combined project which involves the Australian and New Zealand College of Anaesthetists (ANZCA), the Australian Society of Anaesthetists (ASA) and the New Zealand Society of Anaesthetists (NZSA). The ANZTADC project is administered by ANZCA.

The ANZTADC project has collected 2193 incidents at the time of reporting. The members have reported incidents that include assessment, documentation, infrastructure, respiratory, cardiovascular, neurological, other organs, medications and equipment.

b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

ANZTADC releases regular reports which are published in the Australian and New Zealand College of Anaesthetists Bulletin, the Australian Society of Anaesthetists Newsletter and the New Zealand Society of Anaesthetists Newsletter.

In addition to the reports there is a presentation of the results at the annual scientific meetings of each of the parent organisations resulting in three presentations annually.

ANZTADC reports regularly to the ANZCA Quality and Safety committee.

c) List what recommendations have been (or are to be) made as a result of the activity:

At the ANZCA Annual Scientific Meeting in May 2014 an analysis of the incidents involving anaphylaxis was presented.

This year an analysis of the problems encountered with difficult airways has been commenced and the results will be presented at the Annual Scientific Meeting of the ASA in October 2014. 
d) Describe how implementation of these recommendations will be monitored:

Incident reporting to ANZTADC is an ongoing activity. Thus the effect of analysis and recommendations is monitored by a continuous feedback loop.

e) Describe how any improvements to the practice or competence of your organisation, or any of your organisation’s agents or employees, are to be managed:

The organisations are informed by newsletter of global problems that have been reported. Currently the management of these problems are decided at each individual hospital.

f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

As a result of increased awareness of how anaesthetic incidents occur it will be possible to improve quality and safety within the New Zealand health system.

In the future this information will feed into the Australian and New Zealand College of Anaesthetists (ANZCA) guidelines.

The current guidelines are available on the ANZCA website – [www.anzca.edu.au](http://www.anzca.edu.au)

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Annual Report on Protected Quality Assurance Activities

Organisation Name: Anaesthesia Auckland Limited
Reporting Period: 13 April 2013 to 12 April 2014

1. Name of Quality Assurance Activity

Anaesthesia Auckland Quality Assurance Activity
Quarterly Mortality and Morbidity Peer Review Meetings

a) List any problems or issues that have been identified in the course of the activity:

- Availability of suitable airway equipment for use for difficult intubation
- Documentation of difficult airway information on a National basis
- Referral of patients with Cardiac problems from private hospitals without Cardiologists

b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

- Anaesthetist involved made recommendations to Hospital regarding equipment required
- Discussion was had regarding what documentation was required for a patient with airway problems
- Education was given with regards how to contact cardiology services

c) List what recommendations have been (or are to be) made as a result of the activity:

- As above
- Purchasing of suitable equipment recommended
- Setting up of a National Data base for Difficult Airway – work is underway on this issue
d) Describe how implementation of these recommendations will be monitored:

With regular reporting and feedback


e) Describe how any improvements to the practice or competence of your organisation, or any of your organisation’s agents or employees, are to be managed:

Through education of what services are available

By making recommendations that emergency equipment be readily available

By working to improve availability of information relating to difficult airways


f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

Improving the safety of consumers by having appropriate equipment available to use in situations where their safety may be compromised

By establishing a National database relating to Difficult Airways all providers dealing with airway issues will be able to access data about a patient’s airway and improve safety.


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Annual Report on Protected Quality Assurance Activities

Organisation Name: Australia and New Zealand Society for Vascular Surgery (ANZSVS), represented in New Zealand by the Vascular Society of New Zealand


1. Name of Quality Assurance Activity

Australasian Vascular Audit

a) List any problems or issues that have been identified in the course of the activity:

Patency after AV Fistula creation is the only category that has been concerning over this reporting period. This was for 1 surgeon in a small sample of procedures (13) and all outcomes are monitored by an elected audit monitoring committee. A concern is the small number of operations performed by some surgeons, which makes data analysis problematic. A small number of New Zealand surgeons have not provided data. Again only 1% of the patients in the database have not been discharged, which is small but precludes analysis. This will be followed as the hospitals are identified to the administrator. There is near total coverage of New Zealand in the audit.

b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

No action required as performance for the last annual period is acceptable. The annual report for calendar year 2013 can be accessed from:
https://app.box.com/s/6u5c2rsdp2s38um5o9e4

c) List what recommendations have been (or are to be) made as a result of the activity:

Continued surveillance of the outcomes after the 4 major categories of vascular surgical operations. A certificate of compliance is issued upon application. Ongoing monitoring of any underperforming surgeon is important to ensure that there is not a repeated occurrence of any identified outlier’s performance, as it is recognized that in any single year, a surgeon can have a run of bad luck.
d) Describe how implementation of these recommendations will be monitored:

The processes of data analysis and monitoring are now mature. Risk-adjusted outcome analysis methods are robust and the algorithm for managing outliers is accepted by the membership. Any underperformance is closely scrutinized in successive years. Any identified surgeon of concern is particularly closely scrutinized. Sophisticated risk-adjusted outcomes are a hallmark of this audit, using multilevel binary logistic regression analysis.


e) Describe how any improvements to the practice or competence of your organisation, or any of your organisation’s agents or employees, are to be managed:

If a surgeon has truly performed below the expected level after risk adjustment and checking data entry for mistakes then the situation will be discussed with the surgeon concerned and with management of his hospital if required. A surgeon may elect to stop performing the procedure in question or undergo supervision by a suitable colleague or attend a centre of excellence for up-skilling in the procedure. There is the ability to view comparison of New Zealand surgeons and hospitals with the peer group in Australasia in real time in the audit application.


f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

The aim of this audit is to maintain high standards of vascular surgery by collecting data from the peer group and ensuring that an acceptable level of performance is achieved. This activity should instil confidence in the public that there is such a tightly monitored activity producing excellent outcomes. The complete audit loop containing a mechanism to protect consumers from an underperforming surgeon will continue to produce excellence in treatment of vascular surgical conditions. The CPD requirement for audit for fellows of the Royal Australasian College of Surgeons is met by participation in the AVA, which is an approved audit for this purpose.

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Annual Report on Protected Quality Assurance Activities

<table>
<thead>
<tr>
<th>Organisation Name:</th>
<th>Boulcott Hospital</th>
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<tbody>
<tr>
<td>Reporting Period:</td>
<td>April 2013 – March 2014</td>
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</table>

1. Name of Quality Assurance Activity

<table>
<thead>
<tr>
<th>1. Post–operative Infection Audit</th>
<th>4. IV Practice Audit</th>
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<tbody>
<tr>
<td>2. Symptom Control Audit</td>
<td>5. Clinical Documentation Audit</td>
</tr>
<tr>
<td>3. Patient Recovery Period Audit</td>
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</tbody>
</table>

a) List any problems or issues that have been identified in the course of the activity:

1. No problems/issues identified.

2. No problems/issues identified.

3. No problems/issues identified.

4. Some IV sites scores not documented on observation chart each shift.

5. No documentation of vital signs being monitored for local anaesthetic cataract patients. No place for consultant to print name in consent section of admission form.

b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

4. Need for further staff education re documentation of IV site score, and date and time at site, recognised

5. Ophthalmology form to be reviewed to include area for charting of vital signs
   Admission form to be amended to include space for consultant to print name
c) List what recommendations have been (or are to be) made as a result of the activity:

4. Staff reminded re documentation of IV site score in patient notes every shift.
5. Ophthalmology form reviewed to include area for charting of vital signs
   Admission form amended to include space for consultant to print name

---

d) Describe how implementation of these recommendations will be monitored:

4. Monitored through quarterly IV Practice Audit and discussion at IV Committee
5. Monitored through Clinical Documentation Audit

---

e) Describe how any improvements to the practice or competence of your organisation, or any of your organisation’s agents or employees, are to be managed:

4. Quarterly IV Practice Audits and discussion with staff at staff meetings
5. Clinical Documentation Audit and feedback to consultants through memo to make them aware of changes to documentation
f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

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<tbody>
<tr>
<td>1.</td>
<td>Benefits to consumers come from continual monitoring of infection levels resulting in reduced infection risk</td>
</tr>
<tr>
<td>2.</td>
<td>Maintaining good symptom control post-operatively for consumers by reviewing findings of audits</td>
</tr>
<tr>
<td>3.</td>
<td>Maintaining good recovery outcomes post-operatively for consumers by reviewing findings of audits</td>
</tr>
<tr>
<td>4.</td>
<td>Reducing infection risk to consumers from cannulation and maintaining correct administration of IV fluid prescription</td>
</tr>
<tr>
<td>5.</td>
<td>Benefits to consumers come through accurate documentation with the outcome being detailed, comprehensive patient notes</td>
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Annual Report on Protected Quality Assurance Activities

<table>
<thead>
<tr>
<th>Organisation Name:</th>
<th>Bowen Hospital, Acurity Health</th>
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<tbody>
<tr>
<td>Reporting Period:</td>
<td>April 2013 – March 2014</td>
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</table>

1. Name of Quality Assurance Activity

Bowen Hospital PQAA

a) List any problems or issues that have been identified in the course of the activity:

- 1 x SAC 2 event reported to MOH January 2014
- 1 x SAC 1 event reported to MOH March 2014

b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

- SAC 2 event: Internal processes reviewed please refer to the MOH REB report
- SAC 1 event: refer to the MOH REB report

c) List what recommendations have been (or are to be) made as a result of the activity:

- Review of theatre Safety check and time out process
d) Describe how implementation of these recommendations will be monitored:

“Time out” audits performed in August – 97% compliance. Repeat audits December 2014 to monitor the desired 100% compliance


e) Describe how any improvements to the practice or competence of your organisation, or any of your organisation’s agents or employees, are to be managed:

Bowen Hospital Clinical Advisory Committee monitors clinical incidents and clinical audit routinely. This includes matters relating to infection prevention and control. Senior clinical managers review general patient incidents. Reporting and committee format within Wakefield Health mean that minutes and reports from Bowen Clinical Advisory Committee are referred/reported to the Clinical Liaison and Advisory Committee.

All staff and consultants are required to participate in ongoing education and maintenance of professional standards. The latter is checked through our credentialing process and the former is checked through annual appraisal process, which is approved by the Nursing Council of New Zealand. All consultants are required to participate in clinical audit. Results are analysed by the Clinical Advisory Committee. Any variances or concerns are raised with the consultants individually by the Chair. Practitioners then have to respond to any recommendations which have been made.

f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

Framework of care is continually assessed to ensure that patients receive the highest quality level of care at all times. The hospital reviews its own internal processes around patient care by continual review of policies and procedures. Education opportunities are utilised for staff and check on staff’s performance appraised annually. Or evaluation of individual cares taken if there is any cause for concern. Due to our continual review of clinical KPI’s early detection of “clusters” or “practise alerts” would be picked up. Patient questionnaire result evaluation are included in the review of clinical KPI’s

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6 Month Report on Protected Quality Assurance Activities

<table>
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<tr>
<th>Organisation Name:</th>
<th>Bowen Hospital, Acurity Health</th>
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<tbody>
<tr>
<td>Reporting Period:</td>
<td>April 2014 – September 2014</td>
</tr>
</tbody>
</table>

1. Name of Quality Assurance Activity

Bowen Hospital PQAA

a) List any problems or issues that have been identified in the course of the activity:

Nil

b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

N/A

c) List what recommendations have been (or are to be) made as a result of the activity:

Nil
d) Describe how implementation of these recommendations will be monitored:

Nil

e) Describe how any improvements to the practice or competence of your organisation, or any of your organisation’s agents or employees, are to be managed:

Bowen Hospital Clinical Advisory Committee monitors clinical incidents and clinical audit routinely. This includes matters relating to infection prevention and control. Senior clinical managers review general patient incidents. Reporting and committee format within Wakefield Health mean that minutes and reports from Bowen Clinical Advisory Committee are referred/reported to the Clinical Liaison and Advisory Committee.

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## Annual Report on Protected Quality Assurance Activities

<table>
<thead>
<tr>
<th>Organisation Name:</th>
<th>Braemar Hospital</th>
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<tr>
<td>Reporting Period:</td>
<td>March 2013 – March 2014</td>
</tr>
</tbody>
</table>

### 1. Name of Quality Assurance Activity

1. Clinical audits  
2. Case Reviews  
3. Protocol reviews

### a) List any problems or issues that have been identified in the course of the activity:

No specific problems identified.  
All case reviews conducted under open disclosure.

### b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

N/A

### c) List what recommendations have been (or are to be) made as a result of the activity:

Development of targeted educational updates following review of new and existing protocols.
d) Describe how implementation of these recommendations will be monitored:

The Clinical Committee will monitor the implementation of new and revised protocols via case reviews.

---

e) Describe how any improvements to the practice or competence of your organisation, or any of your organisation’s agents or employees, are to be managed:

Targeted education; seminars and workshops.
Competency assessments.

---

f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

Increase in range of clinical procedures and services provided.
Provision of contemporary best practice.

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1. Name of Quality Assurance Activity

College of Intensive Care Medicine of Australia and New Zealand, Continuing Professional Development (CPD) Program

a) List any problems or issues that have been identified in the course of the activity:

Prior to 2012 the College of Intensive Care Medicine of Australia and New Zealand (CICM) did not have a mandatory requirement for Fellows to participate in the College’s CPD program, and only about 25% of Fellows did so. From 2012, however, participation in CPD became a compulsory requirement for all Fellows. Consequently the change from a voluntary to a mandatory system required considerable effort on behalf of the College to ensure that all Fellows were aware of the requirement and were participating. The College CPD program runs in a two year cycle. Over the course of the first mandatory cycle, an ongoing communication strategy was necessary to continually remind Fellows of their obligations.

The change to mandatory CPD for Fellows coincided with the introduction of a new online reporting system.

The initial low participation rate was quickly rectified by targeted mail outs, articles in our newsletters and also assisted by the requirements of both the Australian and New Zealand medical boards for medical practitioners to participate in a CPD program. The cycle was completed with a 99% compliance rate with non-participating Fellows being offered assistance to complete their requirements.

The technical issues with the online system have been remedied with some minor changes to the backend of the system and this caused minimal disruption for the participants.

b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

The initial low participation rate was quickly rectified by targeted mail outs, articles in our newsletters and also assisted by the requirements of both the Australian and New Zealand medical boards for medical practitioners to participate in a CPD program. The cycle was completed with a 99% compliance rate with non-participating Fellows being offered assistance to complete their requirements.

The technical issues with the online system have been remedied with some minor changes to the backend of the system and this caused minimal disruption for the participants.

c) List what recommendations have been (or are to be) made as a result of the activity:

A CPD Committee has been formed by the College Board and this consists of the CPD Officer from the Board, the New Fellows Representative from the Board, a trainee representative and a member of the College staff. This group have been tasked with reviewing the CPD program on a regular basis to ensure it is meeting the needs of the Fellowship, both educationally and also logistically in regards to the online system. The group seek regular feedback from the Fellows and also seek input from other Colleges.
d) Describe how implementation of these recommendations will be monitored:

The CPD Committee must report to the Board on a regular basis to ensure that recommendations are implemented and continued monitoring of the system occurs.

e) Describe how any improvements to the practice or competence of your organisation, or any of your organisation’s agents or employees, are to be managed:

The College audit 5% of its CPD participants at the end of each cycle. Participants chosen for the audit must provide documentation proving completion of required activities (minimum 100 points per cycle, with minimum requirements in a number of areas). The last cycle 45 participants were chosen for the audit, 44 completed within the required time frame and one sought an extension due to personal reasons. The audit process is also monitored by the CPD Committee and in turn the Board.

f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

Regular reviews and critical analysis of the CICM CPD program ensures that it fosters continued learning for intensive care specialists in order to improve standards of clinical practice. The program is devised to encourage the use of currently accepted educational strategies to assist specialists to participate in CPD learning activities that meet their professional and personal needs.

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PO Box 5013
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Dear Sir/Madam,


Please find enclosed the annual report on the participation of the New Zealand Fellows of the College in the Peer Review activities of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Continuing Professional Development (CPD) program: Peer Review Groups and Practice Visits.

This report is presented in order to satisfy the reporting requirements under the Health Practitioners Competence Assurance Act 2003.

Please note that the RANZCP Peer Review Groups and Practice Visits have been operating since 1996 and were originally included in the declaration of the Maintenance of Professional Standards Program on 18 September 1996.

Some 896 Peer Review Groups (PRGs) are currently registered within the College’s CPD program and 107 of these are operating within New Zealand. Members of the PRGs meet on a regular basis, normally monthly. There were 39 respondents to the survey which was circulated August 2014 to inform this report. Given this small number, relevant responses (de-identified) are copied in to answer the report’s questions and are detailed on the following pages.

A recent survey evaluating Practice Visits has been recently carried out, with respondents being participants in the RANZCP Practice Visit program. Only two respondents are from New Zealand, and the report is attached.

Please do not hesitate to contact me if you require further information.

Yours sincerely,

Elaine Halley
Responsible Person under the Act
General Manager, Education and Training
## 1. Name of Quality Assurance Activity

### Royal Australian and New Zealand College of Psychiatrists’ Peer Review Group Activity

a) List any problems or issues that have been identified in the course of the activity:

- None of major significance.
- Most of the group’s members are in private practice and sometimes there is an issue of afterhours urgent or emergency cases that need attending the Public Crises Teams.
- Liaison with family.
- No issues with group.
- Meets weekly and is attended by participants who are not on leave etc.
- No new specific problems but general and ongoing concerns around limitations of resources in Mental Health Services and impact on patients.
- Profile of psychiatrists in MHS; High work load at CAMHS.
- Challenges of report making, lack of knowledge regarding neuropsychiatric symptoms of limbic encephalitis and DID.
- Lack of adequate documentation while clients are transferred from child and adolescent services to adult services.
- Reduced house surgeon cover on the old age psychiatry ward.
- Implementation of delirium pathway for junior doctors.
- Lack of inclusion of psychiatric aspects suggested by liaison psychiatrist.
- In general there have been no major issues. At times because of work pressures and demands some of the group members are unable to attend.
- Diagnostic issues, medico-legal issues, ethical issues, medication issues,
- Stretched resources in acute inpatient, rehabilitation wards, and for clients in prison, influencing clinical decision making.
- Long term care and rehabilitation beds.
- Systems issues with a lack of inpatient beds for children and adolescents with Intellectual disability/autism with significant aggression.
• Management of complex somatoform disorders. Risk of iatrogenic narcotic dependency from liberal prescription of oxycontin and oxynorm for patients with non specific pain. Higher than expected number of lithium toxicity cases coming to attention of liaison psychiatry
• Limited access to neuropsychological assessment in Adult Mental Health Service at times poor communication between parts of the service. Ethical issues
• Lack of Senior Medical Staff.
• Consultants being told to work in areas they are not entirely comfortable working in
• Service delivery, care of complex cases, supervision of junior staff
• Interface difficulties with crisis intervention service
• Lack of acute beds.
• Lack of supported accommodations
• Inadequate services for ID clients
• Standards for clozapine monitoring - treating health professionals - metabolic monitoring for antipsychotics
• Establishment of treatment management plans for chronic psychiatric patients
• Incomplete handover of patients between services
• Discrepancies in the provision of health care based on geographical location, age and gender, diagnosis.
• Use of tests of effort highlighted in recent reports reviewed.
• Tests of effort by psychologist could add to validity of court report conclusions
• A lack of dual diagnosis services (intellectual disability and psychiatry) for under 18 year olds.
• No specific problems were identified in terms of the delivery of care; typically cases are presented where there is no clear answer, and clinicians are presenting with respect to future management. Robust discussion occurs but no problem with provision of health care that required intervention was identified.
• Treatment resistance to antipsychotics. Team dynamics. Impaired colleagues. Provision of DBT
• Audit of Clozapine Treatment resistant depression
b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

- Attempts at better and constructive liaison with the Public Services
- Clinical audit/literature review/focus on issue/due for re-audit
- Discussion involves clinical, ethical, systems/organisational issues
- Communicating concerns to Mental Health Services
- planned to participate in MH awareness week, strategic use of time and assessment strategies to allow dictation topics, scientific report emailing
- It will be ensured that there will be systematic collection of baseline data and follow up data and later recorded in the clinical notes
- Continue discussion with medical team.
- Email and text reminders are sent an hour before the time to enable members to plan the day.
- Careful note taking and documentation of risk, diagnoses changed, medication changes, further investigations, advice from indemnity insurers
- Letters have been written to management expressing concern, by members of group. The extra resources needed have been communicated.
- Issues raised with clinical director
- Advocacy to management. Discussion with adult services for patients with similar presentations.
- Group Discussion, Literature searches
- When the opportunity allows, discuss the problems / issues with health managers and politicians drawing their attention to the discrepancies.
- Useful discussion. Literature searched and shared. Support for team functioning.
- Identification of communication gaps and effects of the consequences on the efficacy to implement clinical actions of the Psychiatrists.
- Review meetings with Clinical coordinators.
- Serious incident review process taken in respect of one clinical situation (this was going to occur, irrespective of PRG input). Increased awareness amongst PRG members of need to ensure full handover
- Clinical Director and Medical Director informed
- Above problems have been discussed with managers of acute services
- Consensus on physical monitoring for patients on antipsychotic medication
• Ongoing discussion in PRG, approach to international expert for education to inform practice. Consider involving clinicians from other specialties. This is a long term process. This will take a long time and a lot of working with other clinicians as we only see the problem cases. Seek information from experts in the field. Talk with colleagues overseas re their experience. Look for models to work with. Audit of such in the various hospitals we are involved with. Presentation to professional groups.
• Advocate for better access to neuropsychological assessment and encourage direct doctor to doctor communication
• PGR members have raised these issues with the management
• Peer review support and advice
• Involvement of medical staff in crisis intervention
c) List what recommendations have been (or are to be) made as a result of the activity:

- Confidential, supportive environment to have professional discussion.
- More participation in local MH consumer initiatives to discuss work load with administrators to allow for time and to report strategically; use of email to circulate useful articles.
- Consultant to consultant contact will precede the transfer of clients.
- A detailed account of the care provided as well as recommendations for future management will be forwarded to the new consultant who will be providing the care.
- Ongoing discussion with managers to reinstitute a full time house surgeon on the old age psychiatry ward.
- Suggestions by liaison psychiatrist should be taken into consideration.
- Monitor patient progress.
- More inpatient resources including bed numbers in the acute adult and adolescent wards.
- Request for operational managers to consider.
- Advocated for an appropriately staffed and developmentally appropriate small number of beds.
- Better management of Depression; Better practice regarding Clozapine prescribing.
- Better handling of staff-related ethical issues.
- The need for ongoing advocacy.
- Specific medication recommendations. Use of group experience of similar problems shared and suggested as ways of managing complex situations.
- DBT is a relevant and important component for treatment.
- Support our colleagues with a proposal for service.
- Recommending closer better documented monitoring.
- Encourage more direct communication.
- Management to address recruitment and retention of Senior Medical staff.
- Morning meeting for crisis intervention service with key medical staff.
- Sender of referral handing over patient should check with recipient that handover received.
- Advice on maintaining boundaries and options for treatments.
• Focus for emergency services must be towards those with an acute psychiatric illness and to direct others to social services etc
• Metabolic monitoring and ECGs should be considered annually for patients on antipsychotic medication
• Implementation of clear diagnostic formulations which result in development of better management plans and more transparent communication
d) Describe how implementations of these recommendations will be monitored:

- Reviewing cases that have been referred
- Group members check in with each other at each meeting
- Regular updating in PRG meetings
- Periodic audits/ 6 monthly audit cycle
- Monitoring of medical care, and what medical care is managed increasingly be registrars. Individual case discussions with medical team in the liaison setting.
- Ongoing monitoring of these difficulties.
- Ongoing observations of the difficulties providing health care and meeting the needs for supporting patients.
- Keeping abreast of implementation or otherwise of health care programs.
- All reports are proof read by clerical staff
- By further discussion and checking with members about outcomes.
- Review of cases within Peer Review Group
- Monitor efforts by management to address recruitment and retention.
- Follow up discussion in peer review to monitor outcomes
- Monitor availability of beds and accommodation.
- Regular review by the PRG members and discussion in the group.
- Liaison with service triage staff.
- Review documentation
- Discussions with in the organisations and audit
e) Describe how any improvements to the practice or competence of your organisation, or any of your organisation’s agents or employees, are to be managed:

- By continuing to have robust peer review of clinical cases
- Any recommendations will be instigated in consultation with service management
- Knowledge and wisdom shared
- Individual and PRG combined participation
- All the completed reports and other information will be maintained in the electronic format
- Broader perspective on issues discussed.
- Further discussions in grand rounds and journal club
- As with other matters, improvements are managed through regular open discussions within the group.
- Demonstrated practice improvements recorded
- We have an open and honest forum for discussion of the competence of PRG members as well as the adequacy of organisations and services.
- Follow up reports on progress on action points is provided at subsequent PRG meetings
- Members of the Peer Review Group do participate in forums supporting individuals and organisations providing health care at various levels of the health care system.
- Revisiting past problems, the group checks on progress of particular issues.
- Up skilling in DBT
- Overseen by Clinical Director and senior service manager
- PGR members to feed back on the progress and efforts of management.
- Self-reflection and return cases to peer review for further comment and update.
- Regular annual report to clinical director. Regular feedback at PRG
- Abide by development of practice guidelines
- Improvements are to be monitored on a regular basis by staff meetings and empirical observation of PRG members which is on regular basis brought back into the PRG.
- Review files and informing the management team.
f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

- Liaison with clients families increases support, reduces relapse
- Clinical, cultural and social competence enhanced by attending peer review.
- A general impact - communication between sectors improves safety and coherence of treatment.
- Improved psychiatrists profile for local consumers administration awareness of high work load; CAMHS might result in increasing resources reports more comprehensive, compact and personal improved knowledge of clinicians of diagnosis of limbic encephalitis and DID
- To facilitate easy transfer and to reduce the stress arising from moving from one service to another service
- Improvement in patient care in a population that often has very complex psychiatric and medical issues.
- The ultimate aim is improving the quality of care to our patients and this is the main focus of the peer reviews.
- Better mental health outcomes and improved patient management
- Improved quality of care.
- Enhance individual clinical practice
- PRG encourages open discussion about the assessment and management of patients with complex presentations as well as systems difficulties. This assists in providing best possible care within available resources and has led to advocacy for more effective services over a range of services including mental health services.
- Improved outcomes for patients Improved and more satisfying work for colleagues Increased support of colleagues with less isolation
- There would be less discrimination of the disenfranchised patients that are the focus of the Peer Review Group.
- Useful and safe sharing forum where members can hear and be heard. This is useful as a form of stress management as well as a forum to learn and share ideas. This has led to better outcomes. Also stating that an issue has been discussed at peer review allows more confidence for the practitioner in an area where there is no right or wrong answer.
- Improved treatment
The group meeting have provided an opportunity to discuss issues and patient management which has been useful.

Clinical management of patients is likely to be improved following the discussion of various clinical issues and getting a variety of perspectives.

More timely interventions and less duplication of services.

More appropriate cultural awareness for consumers of the service.

Consumers benefit from their treating psychiatrist being able to access the experience and views of colleagues in the group.

Better physical health care for patients with severe mental disorders.

Increased transparency and better implementation of treatment management plans. Decreased waiting time in communities, improved aspect of safety.

Patients will receive continuous care.

Consideration of practice.

Getting support and the assessing the right advice.

Long term project, outcome would be saving money, reduce medical dependency. Reduce risk of iatrogenic narcotic dependency. More accessible service with better coordination between carers at the particular level of illness process. Fewer people suffering avoidable medical complications.

Better communication results in better clinical outcomes.

Consumers benefit from consistency and maintenance of quality in health care.

Maintenance of best-practice principles with unconditional support.

Ensure psychiatrists in the group complete CME requirements to remain registered with the Medical Council.

Improved court reporting.

Ongoing maintenance of learning in the forensic context - medico legal issues.
g) Please note any further comments about the PRG below:

- PRG is much appreciated by members and considered supportive and inspiring.
- This peer review group meets weekly, monthly only consultants and on other weeks registrars and trainee interns supervised by the consultants of this group, are invited as well.
- The members have found the group meetings to be valuable.
- The members have found the meetings to be of value in discussing options in clinical treatment.
- The PRG is working well as trust has developed so that errors can be discussed in an honest and open manner and corrections made to improve practise.
- Our group is not a performance management tool but a clinical resource for participants.
- Consultant Psychiatrist jobs can be isolating and stressful. PRG help to support consultant and seek advice and help.

Please send to: Clinical Leadership, Protection and Regulation
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1. Name of Quality Assurance Activity

- General Practitioner and Nursing peer review groups
- Reportable Event Management
- Clinical Audits
- Referred Services Audits
- Contractual Customer Satisfaction Surveys

a) List any problems or issues that have been identified in the course of the activity:

- Peer review – Compass Health (CH) maintains a database of peer review groups attended by Compass GPs and Nurses. From reviewing the number of groups registered and attendees we know that not all Compass Health GPs register their activity through Compass. Some GP peer review groups report directly to the College. Ongoing promotion occurs to promote and support participation in these activities with an increasing number of nurses actively participating in peer review this year.

- The Compass Health Reportable Event Management process needed reviewing so it aligned with the Health Quality & Safety Commission (HQSC) recommendations, including Severity Assessment Code (SAC) rating and national reporting. Reportable event reporting has increased in recent years following promotion to General Practice but the numbers of reports received are lower than would be expected.

- Clinical and referred services audits – audit processes need to be added to the yearly calendar with evaluation of outcomes sent to Clinical Quality Board (CQB) for further recommendation. Education needs to follow audits in line with Clinical Quality Improvements.
b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

Peer review – problems/issues are being addressed
• The peer review guideline, peer review registration form and a peer review reporting template are regularly distributed to practices and are available for peer groups.
• Peer review groups are registered with the Continuing Professional Development coordinator (CPD) at CH, minutes and attendance records are forwarded to the CPD coordinator, and certificates of attendance are sent to attendees.
• Promotion of peer review requirements for nurses and GPs are regularly promoted to primary care.
• Clinical supervision and reflective practice options are regularly promoted to staff

Reportable Event Management - problems/issues are being addressed
• The reportable event management policy has been reviewed to incorporate a more robust process for serious and sentinel reporting. Compass Health has collaborated closely with the Health Quality & Safety Commission to ensure that the process for reporting general practice SAC 1-2 is safe and accurate. This process was agreed on, and moderated by, CCDHB and has General Practice backing with all information supplied being anonymised with main focus on sharing clinical learning’s. Education sessions have been completed to ensure the revised policy is well implemented across primary care.
• There have been 19 reportable events reported to CH during this one year period. All events have been followed up and managed accordingly at practice level and within the relevant CH clinical teams. All events have been reported to the CQB and are now closed following completion of recommendations. Key learning’s from the events are included in the bimonthly Quality newsletter to practices. Any education needs are forwarded to the CPD coordinator for inclusion in education sessions.

Clinical audits - problems/issues are being addressed
• Annual practice visits and clinical risk reviews continue with follow up provided by management, clinical and practice liaison staff as required. These processes include audit and clinical processes, along with other contractual compliance.
• CH continues to identify and work with practices that require further training or up-skilling in the use of their Patient Management Systems to use these more effectively to obtain accurate data when doing clinical audits.
• Routine clinical audits of internal staff are included in the yearly calendar with evaluation going to CQB with all recommendations followed up. Identified education requirements are forwarded to the CPD coordinator for inclusion in education sessions.
• Practices are reminded via the Clinical Quality Board (CQB) newsletters to carry out clinical practice based self-audits. We continue to actively encourage practices to carry out 6 monthly cervical and immunisation self-audits as part of our PHO Performance Programme (PPP). This programme and the associated data made available from DHBNZ provide opportunities to evaluate clinical and referred services.
• Continuing Professional Development (CPD) continues to be provided to enhance best practice, promote and assist in the up-skilling and ongoing learning for practitioners. CH continues to be an accredited CME Provider with the Royal NZ College of GPs (RNZCGP).
c) List what recommendations have been (or are to be) made as a result of the activity:

- The Reportable Event Management policy has been reviewed, giving more clarity around reporting of serious and sentinel events, and external reporting requirements.
- Identified education requirements are incorporated into the CDP calendar – e.g. reportable event management, clinical supervision and reflective practice processes.


d) Describe how implementation of these recommendations will be monitored:

- All recommendations made are implemented as required via newsletters, weekly mail outs of information to practices, and face to face with practice teams.
- Ongoing reporting of reportable events is monitored by CQB
- Continuing Professional Development workshops to support ongoing learning, practice and PHO staff will continue. All recommendations will be monitored via CH’s Clinical Quality Board when appropriate.


e) Describe how any improvements to the practice or competence of your organisation, or any of your organisation’s agents or employees, are to be managed:

- Practice outliers will continue to be managed via the Performance Variation policy when necessary.
- Clinical audits will continue as per the clinical audit policy.
- Clinical facilitator and peer visits will continue to occur providing best practice evidence/education for practitioners
- An extensive CPD programme will continue to be provided to ensure all clinical staff have opportunities to update their knowledge and clinical expertise. This will be managed by CH’s Clinical Quality Team.
- Peer supervision/review will continue to be supported, with the clinical guideline, registration form and reporting templates.
f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

- Clinical Governance and processes are actively in place within the organisation to promote Continuous Quality Improvement.
- Clinical effectiveness is promoted through peer review processes.
- Participation in peer review provides a forum to discuss learning in a safe environment.
- Risk management systems monitor and minimise risk to patients and staff and provide opportunity to learn. Risk management occurs through reporting of reportable events.
- Positive events are also reported to the organisation so we can share and celebrate positive occurrences and learn from these.
- Clinical audits ensure GP Practices and their staff are aware of gaps in service provision and enables the ability to track this and associated improvement.
- Referred service auditing ensures that outliers are visited and behaviour change is supported to ensure best evidence based practice occurs within appropriate guidelines and available resource.
- Both Referred Services audits and Clinical audits are carried out regularly to assess outcomes directly related to key performance indicators. These assist in planning and implementing future service delivery, improving health outcomes and reducing health inequalities for high needs populations.
- Clinical leadership and support is in place within the organisation to assist practitioners to provide safe and effective, evidence based, best practice care.
- Processes are actively in place within the organisation to promote learning from reporting of reportable events, peer reviews, clinical audits and clinical supervision to enable staff to be competent in doing their jobs while developing skills.
- Overall, the health and safety of members of the public will be protected through the provision of mechanisms which ensure that CH practitioners are competent.

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Annual Report on Protected Quality Assurance Activities

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<th>Organisation Name:</th>
<th>Counties Manukau Health</th>
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<td>Reporting Period:</td>
<td>Till August 2014</td>
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1. Name of Quality Assurance Activity

1. Middlemore Geriatricians monthly QA and difficult cases discussion.
2. Colposcopy Pathology monthly multidisciplinary meeting.

a) List any problems or issues that have been identified in the course of the activity:

- Systems issues to do with patient care
- Difficult clinical decisions regarding specific patients
- Monitoring of key departmental outcome measures
- Variations in reporting and practice.

b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

- System modification as needed
- Advice and peer support to individual consultants
- Ongoing audit and feedback
- Review of and adherence to guidelines
- Regular audit of practice
- Streamlining communication
- Encourage discussion.

c) List what recommendations have been (or are to be) made as a result of the activity:

- Several as per above – these recommendations are Minute and acted upon.
- Ongoing review of guidelines and audit of practice.
- Consensus regarding difficult cases.
d) Describe how implementation of these recommendations will be monitored:

- Review of Minutes at next meeting to confirm actions have been undertaken (where necessary).
- Ongoing peer review, group discussions and audit.

e) Describe how any improvements to the practice or competence of your organisation, or any of your organisation’s agents or employees, are to be managed:

- Ongoing meetings and performance review (in addition to the everyday management of activities).
- Ongoing monitoring of complaints.

f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

This meeting is about the quality of care in the department, to enhance patient (and whanau) experience

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