Annual Report on Protected Quality Assurance Activities

Organisation Name: The Royal Australasian College of Physicians

Reporting Period: October 2012 – October 2013

1. Name of Quality Assurance Activity

The Royal Australasian College of Physicians MyCPD programme

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

Within the Royal Australasian College of Physicians (RACP), Fellows are expected to obtain a minimum of 100 credits in the MyCPD programme, as well as completing the Medical Council of New Zealand’s (MCNZ) requirements of 10 hours of peer review and undertaking one audit per year. Concerns were raised this year by members of the RACP Faculties that the requirement of completing one audit was difficult to meet for those specialties that do not have any/much patient contact.

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

Through two New Zealand based newsletters, Fellows are kept up to date with any changes to the MyCPD programme, such as the inclusion of mandatory peer review and clinical audit and are given advice on how to make the programme easier to use. The CPD contact in New Zealand, along with members of the NZ Continuing Professional Development (CPD) Committee continues to run training sessions at hospitals throughout the country and also attend conferences throughout the year to answer questions on CPD.

In response to the above question, this reference to a clinical audit and how a physician with limited patient contact can successfully complete one per year was discussed with the MCNZ who has since changed their terminology to the doctor being required to participate in one review of medical practice per year, along with the other MCNZ requirement of undertaking 10 hours of peer review per year. This has satisfied the Faculty members. The MCNZ also provided clarity around what types of activities can be claimed as a review of medical practice and this was disseminated out to MyCPD participants.
c) List what recommendations have been (or are to be) made as a result of the activity:

The Royal Australasian College of Physicians is continuing to encourage Fellows to identify areas of their practice which fit into the peer review and clinical audit areas as many Fellows will already be meeting the requirements but perhaps not recognising them and not entering them into the MyCPD programme appropriately. This is also being tracked through the annual Random Review process whereby 5% of all MyCPD users across NZ and Australia have their CPD activities for the previous year audited. We can use this data to identify what activities MyCPD users have entered into the peer review and review of medical practice / clinical audit categories and assess whether there needs to be further communication around these requirements, through the hospital visits and in the newsletters.

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

Use of The Royal Australasian College of Physicians MyCPD programme continues to be monitored, including analysis of involvement in performance improvement measures and use of quality assurance tools by Fellows. Data reports are regularly run on MyCPD participants’ progress and staff at The Royal Australasian College of Physicians are able to contact Fellows who may not be progressing with their CPD to see if assistance is required. Assistance can be in the form of a tutorial over the phone or in the office or by asking a member of the NZ CPD Committee in the same hospital/area to contact the Fellow to provide assistance.

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 Royal Australasian College of Physicians continues to develop MyCPD to assist Fellows improve their performance. A Regular Practice Review (RPR) framework has been developed and the Service Review section has recently been piloted at an Auckland hospital. The physicians who participated in the Professional Development Review (PDR) and the Service Review components of the RPR are currently providing their feedback on the process via a questionnaire to help the RACP understand what aspects work well and what aspects may need modifying. The RPR is another way to measure competence in physicians practice and this will be incorporated into the Royal Australasian College of Physicians MyCPD programme. The RACP has developed several publications over the past year with the aim of providing resources for our members on different areas of practice. The publications are “Physicians in isolation” and “How to survive as a new consultant”. These publications have been made available to our Fellows and trainees.
f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

Consumers stand to benefit from the ability for Fellows of the Royal Australasian College of Physicians to accurately and freely assess their own practice and performance and make concrete plans to address any areas of deficiency identified.

Please send to: Population Health
Ministry of Health
PO Box 5013
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qaa@moh.govt.nz
## Annual Report on Protected Quality Assurance Activities

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<th>Organisation Name:</th>
<th>The Royal Australasian College of Physicians</th>
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<td>Reporting Period:</td>
<td>October 2011 – October 2012</td>
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### 1. Name of Quality Assurance Activity

The Royal Australasian College of Physicians MyCPD programme

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

Within the Royal Australasian College of Physicians, Fellows are expected to obtain a minimum of 100 credits in the MyCPD programme. In 2011 it was confirmed that MyCPD participants must also comply with the Medical Council of New Zealand’s (MCNZ) requirements of completing ten hours of peer review and a clinical audit within these required 100 credits. The MCNZ also encouraged health practitioners to practice cultural competence as part of their CPD, while this aspect is not mandatory in CPD currently, it may become so.

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

Through two New Zealand based newsletters, Fellows are kept up to date with any changes to the MyCPD programme, such as the inclusion of mandatory peer review and clinical audit and are given advice on how to make the programme easier to use. The CPD contact in New Zealand, along with members of the NZ Continuing Professional Development (CPD) Committee continues to run training sessions at hospitals throughout the country and also attend conferences throughout the year to answer questions on CPD.

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

The Royal Australasian College of Physicians is continuing to encourage Fellows to identify areas of their practice which fit into the peer review and clinical audit areas as many Fellows will already be meeting the requirements but perhaps not recognising them and not entering them into the MyCPD programme appropriately. This is also being tracked through the annual Random Review process whereby 5% of all MyCPD users across NZ and Australia have their CPD activities for the previous year audited. We can use this data to identify what activities MyCPD users have entered into the peer review and audit categories and assess whether there needs to be further communication around these requirements, through the hospital visits and in the newsletters.
d) Describe how implementation of these recommendations will be monitored:

Use of The Royal Australasian College of Physicians MyCPD continues to be monitored, including analysis of involvement in performance improvement measures and use of quality assurance tools by Fellows. Data reports are regularly run on MyCPD participants’ progress and staff at The Royal Australasian College of Physicians are able to contact Fellows who may not be progressing with their CPD to see if assistance is required. Assistance can be in the form of a tutorial over the phone or in the office or by asking a member of the NZ CPD Committee in the same hospital/area to contact the Fellow to provide assistance.

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 Royal Australasian College of Physicians continues to develop MyCPD to assist Fellows improve their performance. The Clinical Performance Framework, called ‘Supporting Physicians’ Professionalism and Performance (SPPP) which provides additional tools to manage Fellows’ performance improvement has been formally launched and has been integrated into the MyCPD programme, the Royal Australasian College of Physicians has also developed guideline commentaries around cultural competence – focusing on how to interact with Māori patients and their whānau, end-of-life care and research with Māori – these commentaries align with the Medical Council’s view on the importance of cultural competence in daily practice. Peer review, clinical audit and cultural competence have been entered into the ‘Specialty Areas’ section of MyCPD and this allows MyCPD users to specifically track the number of hours the relevant activities have accumulated throughout the year. This breakdown is also included on the users ‘statement of completion’. A Regular Practice Review (RPR) framework has been developed and the Service Review section will be piloted at North Shore Hospital. The Professional Development Review (PDR) has already been successfully piloted within a department of Middlemore Hospital.

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

Consumers stand to benefit from the ability for Fellows of the Royal Australasian College of Physicians to accurately and freely assess their own practice and performance and make concrete plans to address any areas of deficiency identified.

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Annual Report on Protected Quality Assurance Activities

Organisation Name: Royal Australasian College of Surgeons
Reporting Period: 15 April 2012 – 14 April 2013

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.

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 College requires surgeons to participate in audit activities as part of their annual continuing professional development (CPD). As of 12 November 2012, the ANZGOSA Audit is an approved focused audit in the College CPD program and, as such, the audit is promoted to surgeons as a means to quality assure their practice.

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. A reporting suite was introduced to the online portal in July 2012. The reporting suite compares patient outcomes for a surgeon’s individual practice against the bi-national aggregate. Three reports are available: Outcomes, Complications and Length of Stay. Reports can be accessed at any time through the online portal and are generated using real-time data. These will allow surgeons to reflect on their own practice, see outcomes and adjust treatment recommendations as necessary. An exporting function will also be added in 2013 to allow for further analysis by individual surgeons.

An institutional upload program is in development. 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 performance assessment, with the ultimate aim of improving surgical care for patients with oesophago-gastric cancer or gastrointestinal stromal tumours in Australia and New Zealand.

Once the institutional upload program is in place, the ANZGOSA Audit will be in a position to report on aggregate results and conduct research into treatment of oesophago-gastric cancer and gastrointestinal stromal tumours, giving us an accurate picture of treatment across both Australia and New Zealand.

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### Annual Report on Protected Quality Assurance Activities

**Organisation Name:** Royal Australasian College of Surgeons  
**Reporting Period:** 15 April 2011 – 14 April 2012

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<tr>
<td>Australian and New Zealand Gastric and Oesophageal Surgical Association Audit (ANZGOSA Audit)</td>
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#### a) List any problems or issues that have been identified in the course of the activity:

Data collection for the ANZGOSA Audit began in August 2010. A preliminary report on the data was produced in March 2011, however, as only a small amount of data was available for analysis, no conclusions were drawn. The analysis did bring to light some issues with the database structure.

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

An upload program is currently in development. This program will allow data to be uploaded from existing large databases. It is estimated that once this is in place, the ANZGOSA Audit will be collecting up to 90% of eligible cases. We will then be in a better position to analyse results.

Alterations to the database structure were completed in 2011. These changes will improve the ability to analyse data in the future.

Minor changes to the dataset will also be introduced in the next upgrade of the portal to include further details for auditing (e.g. hospital admission date to allow for length of stay reports).

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

The aim of the ANZGOSA Audit is to provide self-auditing capability for members of the ANZGOSA. Surgeons will be able to analyse their own data and compare their performance with the bi-national aggregate for patient complications, length of stay and outcomes (mortality, readmission, reoperation etc.).

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

Automated reports are in the process of being developed and will form part of the online portal. Users will be able to log in to access these reports at any time. It is anticipated that these reports will be available in the second half of 2012. This should improve utilisation.

#### 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 audit functions as a self-audit tool. Individual participants are expected to use the audit to identify any issues with performance and initiate improvement.
f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

The bi-national collection of this data will add to the knowledge base of these cancers and allow the forming of a baseline measurement of surgical treatment. The data can then be used for the development of benchmarks that will guide best practice in treatment. The guidelines will benefit future patients with these types of cancer.

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### Annual Report on Protected Quality Assurance Activities

**Organisation Name:** Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

**Reporting Period:** 2013

1. **Name of Quality Assurance Activity**
   
   RANZCOG NZ Practice Visit Programme

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

   No problems were encountered within the actual review process.

   There were some internal logistical complications regarding travel to practice visits in rural areas.

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

   There will be an ongoing focus on resolving administrative issues.

   No problems were identified arising from the actual reviews.

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

   In 2013 we conducted 10 practice visits. The RANZCOG NZ Practice Visit Sub-committee met on 19 December 2013 and finalised practice visit reports which were sent to the 10 visitees.

   All reports contained feedback in line with the aim of the programme, which is “to provide feedback about the practice and facilitate quality improvements where necessary, in a collegial and supportive manner”.

   No significant concerns arose from any of the practice visits.
d) Describe how implementation of these recommendations will be monitored:

The Practice Visit Sub-committee is currently reviewing all the practice visit documentation to ensure that any recommendations requiring follow up are followed up in a timely manner.

In 2013, one visitee was offered a follow up practice visit to see if the guidance offered in the report had been useful.

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:

- RANZCOG NZ Practice Visit Sub-committee, comprised of RANZCOG Fellows, meets annually and retains oversight over the programme.
- Working party established in 2013 to review the practice visit process and documentation within a quality improvement framework.

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

This PQAA provides RANZCOG Fellows with the opportunity to confidentially review their practice, focusing on the following areas:
- the clinical environment
- patient waiting times
- communication by and with health professionals/the practice team
- and manner in which treatment is delivered

Areas of strength are identified in the report, as are areas of vulnerability and suggestions for improvement.

The Practice Visit Sub-committee offers follow up to any visitees where it has been considered helpful.

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Annual Report on Protected Quality Assurance Activities

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<tr>
<td>Reporting Period:</td>
<td>2012</td>
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1. Name of Quality Assurance Activity

RANZCOG NZ Practice Visit Programme

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

No problems were encountered within either the actual reviews, or the administrative process.

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:

In 2012 we conducted 3 practice visits. The RANZCOG NZ Practice Visit Sub-committee met on 6 December 2012 and finalised practice visit reports which were sent to the 3 visitees.

All reports contained feedback in line with the aim of the programme, which is “to provide feedback about the practice and facilitate quality improvements where necessary, in a collegial and supportive manner”.

None of the visits highlighted any significant areas of concern and therefore no follow up was offered.
d) Describe how implementation of these recommendations will be monitored:

N/A, as there were no recommendations.

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:

- RANZCOG NZ Practice Visit Sub-committee, comprised of RANZCOG Fellows, meets annually and retains oversight over the programme.

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

This PQAA provides RANZCOG Fellows with the opportunity to confidentially review their practice, focusing on the following areas:

- the clinical environment
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- and manner in which treatment is delivered

Areas of strength are identified in the report, as are areas of vulnerability and suggestions for improvement.

The Practice Visit Sub-committee offers follow up to any visitees where it has been considered helpful.

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Ministry of Health
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23 October 2012

The Director, Population Health
Ministry of Health
PO Box 5013
WELLINGTON
NEW ZEALAND

Dear Sir/Madam,

RE: Health Practitioners (QAA – RANZCP Peer Review Groups) Notice 2012 - Annual Report on QA Activities

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 779 Peer Review Groups (PRGs) are currently registered within the College's CPD program and 102 of these are operating within New Zealand. Members of the PRGs meet on a regular basis, normally monthly. There were 32 respondents to the survey which was circulated September 2012 to inform this report. Given this small number, relevant responses (de-identified) are copied in to answer the report's questions.

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

Best wishes,

Elaine Halley
Responsible Person under the Act
General Manager, Education and Training
Annual Report on Protected Quality Assurance Activities

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<th>Organisation Name:</th>
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<td>February 2012 – August 2012</td>
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1. Name of Quality Assurance Activity

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

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

- Symptoms of Tardive dyskinesia emerging following 3 years of treatment with Olanzapine with dose reaching 30mg nocte at some stage.
- Medico-legal case involving a patient who suffered from schizophrenia complicated by significant polysubstance abuse and ending up in suicide.
- Concern re colleague's performance (but not member of our CPD).
- Developing skills in MDT.
- Disseminating knowledge of relevant psychiatric and psychosocial issues amongst house surgeons.
- Difficulties in interfacing with the NGOs delivering (or not) services to our patients.
- Gaps in NGO service provision.
- Conflict between inpatient and outpatient services.
- Issues in report writing.
- Problems related to GPs' of alternative methods.
- Adverse effects of ECT; cardiac or neurological adverse reactions.
- EEG quality with Ultra Brief ECT.
- Organisation of an ECT Service.
- ECT Services need for audit.
- As an example. Coordination between NGO contracted services (EDS) and the regional team with loss of continuity of patient care. Other examples are clinical care based or diagnostic, or include updates from expert sources including conferences attended by group members.
- Clozapine and prolonged QTc.
- Compliance with national Government policies not being resourced by local health authority.
- **Compromised facilities (as a result of damage secondary to earthquakes) have been noted by most members. Negative impact on staff morale as result of earthquake effects and implications for provision of treatment by staff who are themselves stressed.**
- Some gaps in service identified e.g.: relative lack of services for children with intellectual impairment, learning difficulties. No specialised services for the youngest children (under 5). Presentation of some very disturbed 4-6 year olds. Difficulty of reports written for ACC or sickness benefit.
- Consistent failure of accurate assessment.
- Difficulties with diagnosis and/or management of complex cases.
- Disputes between services, difficulties transferring care.
- Ethical dilemmas in the management of patients (such as the use of compulsory treatment), Resource allocation issues, particularly around discharging patients from care.
- Fragmented Psychotherapeutic services for Dual Diagnosis clients and under utilizing of Psychologist.
- Gaps in service e.g. AOD & personality disorder.
- Ritalin use vs. abuse.
- Improvement needed in Rapid Tranquilisation.
• Inadequate resources for Maternal Mental Health Teams leading to long waiting list in Central Auckland, need for stress leave for one PRG member and increased clinical risk due to lack of a mother baby inpatient unit esp. for clients with psychosis.
• For clinicians working in Infant Mental Health Teams, difficulties accessing or co-ordinating care for parents with mental illness.
• Lack of resources, especially psychological rehabilitation.
• Major problem is shortage of acute beds, and the pressure to move unwell patients from hospital to create beds for more acute patients.
• Problems of developing a clinical pathway for depression in an integrated MHS. After reorganisation of Addiction services ethical issue for the Psychiatrist facing issues of lack of service safety.
• Discomfort with Kappa assessment system.
• Long term management of patients and limited access to a full range of therapeutic supports.
• Young Onset Dementia - who has responsibility?
• Interface between Forensic and AM Services.
• Nil (9)
b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

- a-reduce dose
- b-consider switch to clozapine
- Involve medical defence union for advice re: how to respond to the coroner inquiry. The patient had left the local services and joined another DHB about 6 weeks before the tragic act of suicide took place.
- Direct communication with the NGO involved.
- This is not amenable to our direct intervention but we do make representations at managerial level re these gaps.
- Convening joint meetings to address particular problems at the time.
- Advising caution - remember the subject of the report may obtain it e.g. from a lawyer.
- Medical management and diagnostic testing and assessment of adverse ECT effects have been discussed and plans of actions made.
- Constructive feedback on EEG quality via email to evaluate new Ultra brief ECT method.
- Open discussion and exchange of experiences with regard to setting up an ECT service.
- Discussed options for ECT audits by mutual practice visits and reviews.
- No direct action arising from PRG activity, but action has commenced in another forum.
- List of topics for in-service education developed and being delivered.
- Presentations at hospital general medical meetings; liaison meetings with colleagues
- Support and advice to PRG colleagues.
- Enhance knowledge, skills and attitudes of participants.
- Attendance at NDSA meetings to improve service interfaces and advocate for establishment of Mother Baby Units.
- Made representation to senior clinical leaders and management.
- Awareness to Medical Director and Line Manager,
- Referral of client triggered that gap to psychologist for assessment and psychotherapy beyond coping and addiction counselling and to address deeper traumata esp. of childhood allocation meeting once a week for all referrals incl. Addiction.
- Implementation of MDT approach across the disciplines.
- Continue with routine peer review.
- Critical review of Consultant overview through the format of complex case presentations.
- Development of pathways to obtain cardiologist support.
- Discussions regarding Young Onset Dementia - pathway being developed to try to best meet people’s needs.
- Discussions have occurred with management to look at funding more community services, and to change the nature of EPS work so the focus is more psychiatric issues rather than social issues.
- Established a formal policy.
- Feedback to Clinical Director who is part of the group.
- Alternative strategies to deal with DHB senior management.
- Revision of policies to do with Clozapine treatment.
- Issue unresolved, but referred up management chain.
- Peer group opinions have been sought and noted in patient records.
- Psychiatrists utilizing and gaining training and knowledge to update their psychotherapy skills to fill in the gap until get the service delivery.
- Seeking second opinion, changing medication, involving other clinical staff.
- Service issues taken to Clinical Director, individual or team practice modified as appropriate.
- Sharing the burden; suggestions for coping with specific patient related problems.
- Support and advice to colleague including referral to research literature. Other models and services and expert colleagues.
- The PRG does not see itself as a group which is either designed, empowered or aiming to resolve systemic issues in care. Support given to each other to clarify clinical issues and respond appropriately. This can often help clinicians to gain a better understanding of their role, of treatment options and of prioritising the information about a patient.
- Nil (8)
c) List what recommendations have been (or are to be) made as a result of the activity of treatment options and of prioritising the information about a patient.

- Olanzapine and other atypical antipsychotic drugs can precipitate tardive dyskinesia except clozapine.
- Consider low dose regime and avoid polypharmacy.
- Consider switching to clozapine when signs and symptoms of tardive dyskinesia start to appear.
- EEG and CT scan to be used as assessment to rule out other causes of prolonged seizure. Change anaesthetic agent.
- To continue to exchange information about EEG quality and features in future contacts.
- To have regular meetings with theatre staff and anaesthetists regarding ECT.
- Plan to organise practice audits in the future.
- Opportunity for reflection on process, with aim of each member of the group being more effective practitioners and leaders.
- Appointment, recruitment and retention of more psychotherapists and psychotherapy oriented psychiatrists.
- Better integration of psychologist into addiction services.
- Colleagues take on board comments/criticism by peers so as to improve their own practice.
- Audits of the use of antipsychotic versus benzodiazepines for night sedation.
- Protection of colleagues from unreasonable workloads.
- Convening clinical staff meetings to agree on management plans, engaging another psychiatrist for second opinion.
- Generally advice around individual patient management.
- Individual uptake of new ideas as appropriate.
- More involvement of MDT and treatment team in patient care discussions.
- More proactive management of acute behavioural disturbance.
- No specific recommendations outside the discussion within the peer review group meeting.
- Ongoing recommendations for improved perinatal services; nil implemented yet.
- Our discussions usually focus on individual case discussions and suggestions are made for the presenting (treating) clinician to trial.
- Recommendations at a clinical level are often made, considered and acted upon.
- This is not how peer review works. It is a peer led discussion that includes SMOs from a variety of employment settings. Collegial challenge, advice and reflection are the process with aims of each member of the group being more effective practitioners and leaders.
- To follow the Waitemata Clozapine guidelines regarding ECGs and Clozapine.
- To work with management to ensure there are adequate community facilities for unwell people.
- Use pathway of assessment and management in Young Onset dementia.
- Strive for better communication between Forensic and AMHS psychiatrists.
- Nil (7)
d) Describe how implementation of these recommendations will be monitored:

- Monitoring of altered practice is done by individual/team usually bought back to the group for further discussion if issues arise.
- By feedback from presenter.
- By feedback to the group in subsequent meetings.
- Clinical director's role and through monthly business meetings with HR, line managers and doctors.
- Direct communication with psychologist; documentation of referrals in MDT allocation meeting.
- Discussion at Peer Review.
- Six month audit brought back to peer review.
- Follow up with manager or team leader if appropriate.
- Clinical Director attends the group.
- Feedback to group as appropriate.
- Feedback to the group from the presenter regarding the progress of the patient.
- No formal implementation to be monitored.
- It is not an organisation based group. Monitoring of altered practice is done by clinician and usually brought back to the group for further discussion if issues arise.
- Monitoring group. Seclusion rates.
- Ongoing discussion at Peer Review - around follow up cases.
- Ongoing reporting and discussions within ECT Peer Group.
- Presenters give outcome feedback at later sessions.
- Rates of admission to the 2 acute wards will be monitored, as well as the rates of "frequent flyers".
- Reporting back monthly to peer review group.
- Represent cases within agreed time frame.
- Through yearly audit of whether ECGs have been completed for patients taking Clozapine, and whether prolonged QTc has been appropriately managed/referred.
- Nil (6)
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 peer group contacts and future practice visits and audits.
- Cases notated by coordinator for future review.
- Continued education of EPS staff as to what core work is. Also ongoing education of GPs as to what constitutes an appropriate referral.
- Full structured MDT is mandatory for full provision of service delivery to clients for safety and risk prevention.
- Group focuses on individual professional practice to ensure the maintenance of standards.
- Occasionally an issue has been taken to senior management.
- The group leaves responsibility for any changes to the presenting clinician. Colleague confronted about potential unwise decision.
- Individual practitioner improvements as appropriate to individual practice.
- Informally, through discussion.
- Issues arising and recommendations made have generally been at an individual patient level.
- Only relevant to peer review group members.
- Routine peer review.
- Self managed by professional and often fed back to the group for further discussion and review.
- Since recent more resources for psychological assessments and better coordination of leaves within therapy team.
- We do not see our role in the PRG as managing the competence of organisations. To an extent we monitor each other's competence in that we give honest and open feedback about cases presented.
- We have not seen the need to embark on such activity.

- Feedback to the group for further discussion and review.
- Nil (8)
f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

- A highly valuable activity to counter and check practice against new and accepted and professional knowledge, norms and practice guidelines.
- Enhance knowledge, skills and attitudes of participants.
- Beds will be available for the most acutely unwell patients.
- Consumers assured that an individual’s practice is supported by a group of experts.
- Safer competent practice.
- Consumers have assurance that their clinician’s practice is under scrutiny.
- Consumers that clinicians are working within acceptable parameters.
- Trust in the group assures that cases causing difficulty for the clinician are presented in a safe and confidential setting.
- Helping to keep up to date on relevant aspects of physical medicine.
- Consumers get the benefit of their treating clinician thoroughly reviewing their case in order to present it and then getting input from a range of clinicians with diverse experience. In my experience preparing to present often leads me to think of other possibilities and then it is helpful to get the benefit of colleagues’ experiences of a condition or use of a medication. Discussion in the group brings a benefit of a number of “second opinions”, which the treating clinician can then utilise.
- Consumers should get a holistic and coordinated treatment and have less risk of relapse.
- Continued improvement in personal practice through discussion of individual cases.
- Discussion of complex cases, ethical issues, organizational or Ministerial feedback/advocacy as appropriate; dissemination of information from conference attendance.
- Exchange of knowledge of best practice guidelines, expert consensus, and new research evidence to ensure best possible care.
- Improved quality of care is ultimate aim.
- Improves the clinical practice of the members of the group.
- Increased quality, efficacy and safety with less risk of adverse effects for consumers receiving ECT.
- It gives an opportunity to share some of the difficulties that we face to manage some of the very difficult cases. It also helped to get additional inputs for other colleagues for a better management of their clients.
- Learning and gaining knowledge to handle difficult situations is always a positive outcome of PRG activities which enhance our clinical practice and professional development as well as service delivery to health and disability consumers.
- More efficient application of evidence based treatment plans that fit the actual formulation as opposed to merely subjective report of client or past historical diagnoses made in acute, after hours assessments.
- Ongoing acknowledgement for the need of advocating for disadvantaged consumers with service providers.
- Patients have the benefit of a group of psychiatrists discussing complex cases and the most appropriate management.
- Peer support for psychiatrists providing consensus best practice advice regarding their treatment.
- PRG activity serves as ongoing monitoring of participants for best clinical practice.
- Providing a forum to promote professional development thereby improving the quality of the clinical care provided by clinicians to their clients.
- Review of complex clinical cases and obtaining second opinions from colleagues ensures consistency of practice.
- Safer care for those on Clozapine.
- Several wise heads review their case and situation (anonymised) - not just treating clinician.
- Shared knowledge from peers.
- Shorter length of stays. Lowered seclusion rates.
- This group allows a high level review of people’s psychiatric management - particularly those with atypical or complicated presentations. The review is by local experts in the field using the most up to date literature available.
- Nil (1)
22 November 2013

The Director, Population Health
Ministry of Health
PO Box 5013
WELLINGTON
NEW ZEALAND

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 857 Peer Review Groups (PRGs) are currently registered within the College’s CPD program and 105 of these are operating within New Zealand. Members of the PRGs meet on a regular basis, normally monthly. There were 45 respondents to the survey which was circulated August 2013 to inform this report. Given this small number, relevant responses (de-identified) are copied in to answer the report’s questions.

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

Best wishes,

Elaine Halley
Responsible Person under the Act
General Manager, Education and Training
a) List any problems or issues that have been identified in the course of the activity:

- Lack of care available for high risk patient who threatened a psychologist and presented for a court report. The patient hadn't been through regional forensic services and given the magnitude of the charges was unlikely to.
- Challenges of negotiating with ACC.
- Clinical management issues; diagnostic clarification; ethical dilemmas; management issues; inter and intra service coordination problems and conferences experiences.
- Systemic issues with special education not undertaking psychometric assessment for learning difficulties and welfare placements being unsatisfactory. Both of these have impacted on health care provision.
- Mostly focused on ethical issues and management planning with respect to complex and challenging clinical scenarios.
- Responding to the death of a patient in inpatient care; evidence based treatment for rapid-cycling bipolar disorder; dealing with families with no insight into mental health problems; approach to impaired psychiatrists and assessing fitness for work.
- There is an overall feeling of being under pressure with increased volume of work with no corresponding increase in resources, including the consideration of increasing the number of consultants in the service. There is also a reduction in allied health staff compounding the problem.
- Discussed difficulties around the provision of reports to other agencies, particularly the ACC.
- Improper use of psychiatry emergency services with legal and relationship problems. Increased demands for inpatient beds following overdoses.
- Lack of culturally informed practice; lack of sufficient inpatient resources; excessive focus of services on risk management at the expense of meaningful therapeutic outcomes for patients; fragmentation of services into micro-specialised mental health teams with vulnerable coordination between them and compromises in continuity of care.
- Difficult diagnostic or treatment issues for the care of individual patients; difficulties in service delivery of resource limited environment; recording and monitoring of alternative therapies and managing interpersonal interactions within the MDT.
- Collegial relationship with other Departments.
- None other than persistent demands on clinical services activity. This probably indicates that the workforce is probably inadequate for proper requirements.
- Difficulties in the relationship with the inpatient unit and difficulties in the lack of resources in the management of a woman with chronic psychosis. Many other issues.
- Optimal care of women with Bipolar Affective Disorder discussed re medication safety issues. Family violence screening and how this impacts on the ability to provide care e.g. safety of staff and client when CYFS referral is made.
- Lack of managerial support; lack of resourcing; onerous records and documents are multiplying.
• Issues in the provision of health care (which has been discussed) were predominantly related to the clinical complexities of the presented cases, both diagnostic and with regards to treatment or management point of view.

• Most of the issues discussed relate to leadership and management challenges. Examples include: developing policy initiatives for governments including the pathways and relationships required to ensure success; managing difficulties in directing reports; comparing and learning from each other on specific mental health program initiatives; how to measure outcomes in mental health and of mental health services and what is required in modern mental health legislation.

• Service provision generally but inpatient service specifically.

• A group of solo practitioners so cannot influence the public system. Identified insufficient psychiatrists and mental health workers both privately and publicly. Further issues are the unavailability of some antidepressants which have been made available overseas. Main task is to assist with practice improvement for all members by using the Peer Review Group as a forum of betterment and reflection.

• Awareness of some of the Mental Health Act provision and responsibilities. Availability of some pharmaceuticals and rules relating to these.

• Issues include: Case based discussions; service delivery pathways; HR/staff related issues – i.e. impaired colleagues; ethical issues; treatment issues; conference presentation updates; Mental Health legislation including the Mental Health Act; smoking cessation policies and implications; co-existing problem management; DSM v. ICD; E-therapy discussions and medication issues.

• Conflict between inpatient and outpatient mental health teams regarding ECT for unwell patients and treatment of mentally unwell colleagues.

• The following issues have been identified:
  i. Liaison between Mental Health Services, Local Physicians and Regional Eating Disorder Services in management of severe anorexia nervosa.
  ii. Potential physical health issues with the long term use / prescription of benzodiazepine and hypnotic.
  iii. Difficulty in arranging complex care planning meetings and coordinating psychiatric care, case management and community provision.
  iv. Gaps in monitoring of the metabolic syndrome in patients who are prescribed clozapine.
  v. Changes in the WINZ benefits system.
  vi. Inappropriate antipsychotic prescribed for challenging behaviours in LD population, with high levels of polypharmacy.
  vii. Role of metformin in aiding management of hyperglycaemia and weight gain in patients treated with antipsychotics.
  viii. Impact of smoking on clozapine metabolism.

• Discussions around the Mental Health Act with regards to a suicidal patient with MDD and PTSD who was on home detention. The patient was compliant with the medication prescribed and had a carer (his wife was at home).

• Problems and issues identified include:
  i. Excessive work exceptions of the MHSOC audit.
  ii. No MVH Mother and Baby Unit.
  iii. Inadequate use of Adult History Forms.
  iv. Online reports do not adjust for DSM-5.
  v. Electronic medication charting.

• Problems and issues include:
  i. Excessive administrative tasks and report making requirements introduced by non-clinical staff in community mental health
  ii. Lack of support for psychiatrists to increase skills in clinical outcome research e.g. sabbatical leave
  iii. Risk of burning out and depression within staff due to long term and high workload.

• Consent to liaise with families of patients.
• Difficulty with regards to interagency communication and pressure on clinical time.
• Issues identified include:
  i. Communication issues between services in the AMHS. EHR issues not yet resolved.
  ii. Ineffective leadership to resolve unethical practices in a particular service.
  iii. Problems for the steady implementation, streaming and running of locums.
  iv. The role of Psychiatrists in the health service.
• Problems and issues include:
  i. Difficult RCA processes.
  ii. Difficult and conflicting relationships between clinical directors and consultants.
  iii. Difficult inter team dynamics that impact on the provision of care.
  iv. Complex patient care.
• Interface issues with other DHBs and other (general) parts of the hospital.
• Problems faced by crisis staff and night triage during on call hours while determining the safety issues in clients with complex presentation.
• Diagnostic issues; clarification and assessment of risks; and challenging treatment options.
• Resource issues particularly as a group of solo practitioners.
b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

- Assertive liaison with relevant clinical teams; involvement of service clinical director.
- Improved liaison with ACC.
- Discussion and guidance around the issues on the basis of experiences and practical knowledge; help to identify the priority; offer guidance and actively involve in any conflicting situations and sharing knowledge – in particular, with regards to this being used in a clinical setting.
- Continued advocacy and involvement of higher management in relation to education issues and correspondence with the Children's Commissioner with regards to welfare issues.
- Consensus view on appropriate management options.
- Reviewed literature and participated in root cause analysis quality improvement practices.
- Joint pressure on service management but so far unsuccessful.
- Changed the format of reports and sought second opinions on content.
- Education of EPS staff, this has had a limited impact. Inappropriate admissions continue but discharges occur promptly in order to ensure that there are sufficient beds available.
- Providing peer support is probably the only reasonable action we can take in the face of the abovementioned fundamental challenges.
- Audit and re-audit; use of peer advice to modify management plans of individuals patients and review of individuals practice within the wider health care organisation.
- Discussion in peer review groups where both modules are represented and working towards inviting an expert in the area to the group.
- Referred to Division meeting.
- Discussion and exploration of possible remedies; discussions with CD and by CD with other CDs.
- Check clinical practice remains proper and not abbreviated so as to lower standards of care.
- Formally complained about the attitude of some staff and the need for improved communication. Multiple doctors involved in helping containment of difficult behaviour with an emphasis on psychotherapy as well as medication.
- Reviewing of literature treatment of BPAD in pregnancy and breast feeding; providing bodyguard services on phones of all staff in one DHB and taking through issues in more depth with CYFS – the CTFS liaison person is very helpful.
- Presenter/treating clinicians would have taken into account opinions and recommendations from peers and implemented those recommendations in the future management of complex cases.
- Some members have taken successful initiatives in another jurisdiction and engaged in specific follow up assistance one to one. Policy documents and procedure manuals are shared. NZ has specifically learned from suicide review procedures in Australian states. There has been significant cross Tasman sharing in the area of outcome measurement.
- Remain involved in wider discussions.
- Systemic issues - we are unable to influence the system as we are solo practitioners. Medications available are limited by PHARMAC. Group discussions often modify treatment valuably.
- Reminder letters from DAMHS to all doctors in Mental Health outlining Mental Health Act issues. Presentation by NZ experienced psychiatrists about pharmaceutical rules in NZ.
- Education, liaising with each other and other specialists and perseverance.
- A document called 'Accessing Psychiatry Advice' has been put in place. The document provided the relevant information to crisis staff undertaking initial assessments when accessing psychiatrists’ advice.
- Improvement of communication within peer group networks and gradual development of Consultation Liaison services to / within the general hospital.
- Audits, a trial focus on completing forms and re-auditing. We are to review the re-audit later this month.
Through PRG sessions/activities the following has resulted:

i. Participants left with a clearer understanding of the diagnosis and management thereof.
ii. Clinicians were provided with a better and more comprehensive view of patient’s risk profile and a better understanding of how to manage it.
iii. Clinicians were provided with a better understanding of what treatment to use and when, how and what to expect from using that specific treatment.
iv. Actions taken specific to the situation of the suicidal patient suffering from MDD and PTSD. Included modifying antidepressants, referral to psychologists for CBT and enlisting his wife’s support as a protective factor. Lithium also considered.

Providing support and advice to colleagues.

Providing support and encouragement to increase direct communication with agencies. Peer supervision and case discussions.

i. Meeting with ASMS and service management.
ii. MHSOA Audit completed and evidence presented to support reports.
iii. Letter to be written to the local RANZCP branch.
iv. Held a meeting with pharmacies in the area.

i. Discussions with involved mental health managers regarding practicality and negative effects on workload.
ii. Providing adequate support and problem solving on how to achieve organisational support for indicated research plan.
iii. Monitoring psychiatrists’ mental health status and assessing the causes of high workload.
iv. Problem solving work situations to reduce work pressures.

i. As a group, looked and identified what we can do individually to enhance communication including raising issues with consultant groups as a whole around EHR processes and service interfaces.
ii. Endorsing mentoring / individual supervision for new locums in addition to the initial orientation and group supervision that they receive when they arrive.
iii. Reviewing leadership style / self reflection about what would be the optimal role of the service to enhance provision of health care.

Providing support and advice to colleagues.
Providing support and encouragement to increase direct communication with agencies. Peer supervision and case discussions.

i. Ability to prioritise issues.
ii. Ability to access appropriate support networks.
iii. Suggestions of how to manage our own anxiety and that of the team or service.
• A variety of suggestion have been made to the group about further investigation and management strategies for individual cases presentation by participants.
• Referral to the clinical directors of the respective services. Boundary issues identified.
c) List what recommendations have been (or are to be) made as a result of the activity:

- Patient referred to and as a result accepted by forensic community team, the report aiding access to care.
- See ACC as benefitting from considered expert support.
- Ongoing advocacy.
- Increase number of specialists in the service; providing more allied health staff and having the service reviewed by an independent expert.
- The need for good note taking in EPS. To focus on mental illness in RPS rather than social problems which are best dealt with in other settings.
- Providing peer support is probably the only reasonable action we can take in the face of the fundamental challenges.
- Modification of management plans or diagnostic formulations. Advice on interactions with management to improve clinical governance and managing interpersonal conflict.
- Joining three different practices to pool resources of knowledge; to share information and increase group expertise.
- Regular meetings between community staff and IP psychiatrists. Better coordination between services.
- Reviewing of literature treatment of BPAD in pregnancy and breast feeding; providing bodyguard services on phones of all staff in one DHB and taking through issues in more depth with CYFS – the CTFS liaison person is very helpful.
- Predominantly providing recommendations related to re-considering a diagnosis or changing treatment applied. Also, offered recommendations regarding the treatment under the MHA. Some recommendations were related to the cross-cultural aspects in treatments.
- Recommendations have been made on specific staff management issues as well as career development issues or on workforce issues such as recruitment and retention.
- The PRG encourages the advocates not to give up despite numerous setbacks.
- These largely apply to clinical practice for all of us and are generally individual and patient specific.
- DAMHS made aware of concerns.
- Advice and reflection with the aim of members being more effective practitioners.
- Education, liaising with each other and other specialists and perseverance.
- Presenters give feedback at a later date about patients’ responses to suggestions made.
- No formal recommendations have been made (5 similar responses).

i. Recommendations differ on a case by case basis from primary care to limit long term prescribing of benzodiazepines and hypnotics and encouragement to consider careful withdrawal regimes.

ii. The necessity to simplify current community mental health client pathways to improve MDT planning.

iii. Increased liaison with primary care for completion of WINZ certificates.

iv. Need for specialist LD/IDS psychiatrists highlighted.

v. Recommendation that initiation metformin are to be in concurrence with consultation with GP, and ideally by primary care.

- Recommendations specific to the situation of the suicidal patient suffering from MDD and PTSD included modifying antidepressants, referral to psychologists for CBT and enlisting his wife’s support as a protective factor. Lithium also considered.
- The above PRG discussions were documented including risks and benefits.
- Recommendations were made to the specific clinician involved in the patient’s care. At times, clinicians were encouraged to escalate the concerns to team leaders and management.
- If the assessing staff has any concerns regarding the client, the staff may contact the on call Psychiatrist to discuss the issue. However, before contacting the psychiatrists, the assessing staff should have completed the clinical and risk assessments.
- Introduction of a functioning triage of referrals to the service.
• If the assessing staff has any concerns regarding the client, the staff may contact the on call psychiatrist to discuss the issue. However, before contacting the psychiatrists, the assessing staff should have completed the clinical and risk assessments.

  • i. Job sizing.
    ii. The requirement for a Mother and Baby Unit in the North Island.
    iii. Emphasising the requirement for all staff to use forms.
    iv. A requirement for DSM-5 diagnoses particularly to support registrars in their training.
    v. More comprehensive and detailed guidelines to be drawn up.

• We expect that there will be a requirement to make some changes in process via this issue but this will be discussed in the audit review meeting in a few weeks.

• Providing support and encouragement to increase direct communication with agencies. Peer supervision and case discussions.

  • i. Advising to reduce and improve proposed tasks.
    ii. Supporting the application for sabbatical leave
    iii. Ongoing monitoring of workload and work-life balance.

• Involving community teams in inpatient treatment reviews (attendance of these reviews)

  • i. More proactive email / telephone contact between treating clinicians, especially relating to the discharge of patients from inpatient units to community teams.

• i. Ongoing involvement in the peer review process.
  ii. Ongoing utilisation of consultants for support.
  iii. Using legal advice via medical protection services.
d) Describe how implementations of these recommendations will be monitored:

- No further action required report; report (S38 CP (MP)) written – full care arranged.
- Ongoing review of this difficulty at the level of individual patient care.
- Ongoing feedback and review (14 similar responses).
- Feedback on progress to the group at later meetings.
- Monitoring will be via employers’ external processes and not through the PRG’s internal processes.
- Peers to act together to assist management in improving health provision.
- Admissions to acute wards are discussed each week in the PRG. The appropriateness of each admission is evaluated. Discharge meetings now outline more appropriate services e.g. relationship services.
- Feedback to peer review groups; audits and re-auditing and monitoring of CME by the College and Medical Council.
- Not formulated.
- Unclear.
- Performance appraisals of staff with feedback. Regular meetings of clinicians involved.
- As the recommendations did not refer to the provision of health care in a broader sense - the implementation of these recommendations was to be the responsibility of an individual clinician.
- Apart from observations of service development, the pulse and mood of the advocates will be a reliable measure of implementation of recommendations.
- Further discussions about these issues in peer review sessions – participants present follow up of cases for review by the group.
- Monitoring of altered practice is done by the clinician and brought back to the group for further discussion.

   - i. Future peer review sessions involving severe anorexia nervosa.
   - ii. Pharmacies/pharmaceutical companies have become aware of high benzodiazepine prescribing rates in the area. Ongoing feedback to see if rates reduce over time.
   - iii. Monitoring outcomes from pathway and redesigning working groups.
   - iv. Auditing.
   - v. Receiving feedback from clinicians and administrative staff.
   - vi. Current and future peer review discussions.
   - vii. OPC referral data analysis.

- It will be monitored through audit cycles of one of the psychiatrist members of the PRG.
- All cases seen by the crisis staff will be discussed at weekday morning clinical review with the participation of the crisis psychiatrist.

   - i. Hiring more staff particularly within MHSOA.
   - ii. New units to be approved for 3 Mothers and their Babies.
   - iii. More history forms to be completed as a required process.
   - iv. A project has been put in place within Rodney, New Zealand.

- We will need to monitor and re-audit to see if any change has occurred.
- Consultant group meetings should review the intra service issues around effective handovers and smooth transitions between teams regularly. The EHR development group must receive feedback about ongoing difficulties with a view to modify / add what is required to make the process more efficient.
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:

- Gap in service provision exists in theory but service flexibility is commendable.
- Ongoing review of this difficulty at the level of individual patient care.
- This is not within our control.
- Internally preferably through peer support. Involving the Association of Salaried Medical Association where necessary.
- As problems are identified, they are tracked in subsequent peer review meetings and implemented strategies can be re-evaluated.
- Individual participants’ professional development; and reaccreditation and maintaining professional registration.
- Identifying potential solutions.
- Unclear (2 similar responses).
- Performance appraisals of staff with feedback. Regular meetings of clinicians involved.
- Implementation or consideration of recommended alternative diagnostic or treatment options resulted in an improved treatment outcome and care of each presented case.
- As we all work at a policy or management or leadership level, any improvements are subjective and reliant on the conversations held at the next meeting.
- As sole practitioners, these have to be managed by individuals. However reviews often occur in meetings.
- Better knowledge will result in better functioning in the service.

- Documentation and referral pathways and feedback to practitioners.
- As the first port of call, improvements were managed by the clinician itself. If the desired result was not obtained, it would then be escalated and challenged with or without the assistance of the group / peers.
- Regular reports to clinical governance.
- The change in practice will be monitored by the clinical nurse manager and the crisis psychiatrist.

- Encouraging better interface/communication between non-work floor planners/managers and ‘front line clinicians.’
- More support provided for clinical outcome research.
- Providing organisations with feedback of workload and risks of staff burning out.

- Increased understanding and knowledge resulting from regular discussions.
- We prefer the process of investigation / auditing, intervention and then re-auditing / reviewing.
- Through feedback at peer review meetings and ongoing discussions of issues (6 similar responses).
f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:

- Maintaining best practice using collective expert opinion, shared knowledge of evidence (2 similar responses).
- Access to care for a high risk patient without psychosis and having gone through forensic system enabled as a once off.
- Better health care provision through intersection collaboration (5 similar responses).
- Regarding special education, we are hoping that children and adolescents with significant learning issues receive a more comprehensive assessment of their learning issues. We are concerned that children and adolescents may experience multiple foster placements unless there are robust review mechanisms undertaken within the welfare system.
- Provides a forum for the discussion of significant clinical challenges and adverse events. This provides consensus management plans for de-identified patients discussed and all clinicians involved can learn from adverse events.
- Continued attempts to improve delivery of care including self monitoring and assisting colleagues to improve their clinical skills as well as dealing with complex and difficult cases.
- Improvement in practice of members (2 similar responses).
- More time and focus on those clients with severe mental illness. More time to devote to the families and to ensure better education.
- Ensuring that participants are working to a standard that is pro-active and compatible with peers; enabling the use of peer review to enhance the care to individual patients and update knowledge of participants with contemporary practice in keeping with peers.
- Increasing skills to identify the problem and a solution or at least knowing we are providing patients with the best care possible.
- Maintaining good clinical practice in diagnostic assessment and therapeutic interventions.
- Complex cases have been reviewed by the Peer group which have optimised treatment and the care of affected consumers.
- All of us are involved in reorganisation better mental health service delivery at a system level. Consumer engagement and measuring this is frequently discussed. Measuring consumer outcomes is a high priority topic and we frequently compare how we know if services are better or not at a state and country level.
- Having access to a service would be of benefit to patients with improved quality of care being available.
- Improved access and use of pharmaceuticals; and use of the Mental Health Act.
- Collegial experience – members share knowledge, skills and attitude.
- PRG activity allows for evidence-based practice; collegial support and overview; and educational based activity.
- Fair and appropriate access to services.
- The PRG gave us a forum to discuss issues, describing how to best resolve issues and utilise evidence based literature to resolve issues from each of our clinical perspectives. Participants were empowered to challenge preconceived ideas and treatments and consequently felt more positive about work experiences.
- Increasing contact with the families of patients which has resulted in sharing and learning more information and therefore greater support for the patient in the management of their illness.
- Better delivery of effective integrated health care through enhanced communication, expertise and efficient practice. This has resulted in a greater sense of job satisfaction, value and belonging amongst clinicians in the service which therefore reduces the potential of burning out.
- The peer review provides a safe place to openly discuss issues regarding practice and facilitating effective problem solving to increase professional competence (2 similar responses).
- More timely intervention provided to new referrals.
• The discussion will provide a forum for the staff who conducted the initial assessment to update their clinical skills through an in-depth discussion. It will also ensure that the crisis client is properly evaluated and managed to minimise the potential risk of that person harming himself / herself or others.

- i. Improved staff satisfaction and thus being less burnt out.
- ii. Finally being able to meet international standards. That is, registrars and organisations will be able to meet international standards.
- iii. Fewer medication errors or conflicts – all will be readable which will lead to improvements in treatment planning and standards.

- i. Increased availability of clinical staff to consumers.
- ii. Increased knowledge of outcomes in the treatment of consumers and increased occupational interest of involved medical staff.
- iii. Adequate, fit and engaged Psychiatrists are likely to engage better with consumers.

• Increased understanding and knowledge in clinicians; support for improved communication with other agencies and therefore improved outcomes for young people and their families.
g) Please note any further comments about the PRG below:

- Because of the very diverse practices of our members (i.e. private practice working for DHB and private hospitals), we have changed our format from a consistent peer review of randomly chosen cases to allowing individual members to choose what will be of most benefit. Meetings are thus now sometimes based around peer review of randomly chosen cases – sometimes around cases with specific 'themes' or shared difficulties and sometimes around the presentation of clinical and ethical issues separate from a case presentation. Discussion continues to be lively and seems to be able to better encompass the diversity of practice.
- This is an effective group as it has been in action for a few years with the same doctors. A sense of trust has developed so that personal errors can be discussed and ways to improve performance can be implemented.
- We are continuing to work at measuring the benefits of the PRG in better ways.
- The peer review group offers a forum for vigorous debate on a range of clinical issues. Despite the frustration of expertise being wasted outside the Peer Review Group, the collective wisdom of the group benefits from these discussions.
- A highly valued activity.
- Members find the process of presenting and receiving suggestions about their cases very valuable. Hearing about cases from different areas of practice is helpful in keeping members au fait with practice in different subspecialties.
- The clinicians who have attended the peer review have found it to be an incredibly valuable experience from the perspective of having a safe milieu in which to process difficult areas of health care provision, reducing burning out / sense of isolation and enhancing transparency and the clinician’s wellbeing. This in turn has a positive impact on the provision of health care for patients.

Please send to: Population Health
Ministry of Health
PO Box 5013
Wellington
qaa@moh.govt.nz
## Annual Report on Protected Quality Assurance Activities

<table>
<thead>
<tr>
<th>Organisation Name:</th>
<th>Royston Hospital Acurity Health Group</th>
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<tbody>
<tr>
<td>Reporting Period:</td>
<td>December 2012 – December 2013</td>
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### 1. Name of Quality Assurance Activity

Royston 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:

Nil

### 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:

Royston Hospital Management team monitor new clinical incidents at weekly meetings. All credentialed specialists participate in clinical audit. Clinical incidents and clinical audits are reported to Royston Clinical Advisory Committee (CAC) at monthly meetings and to Acurity Health Clinical Liaison and Advisory Committee (CLAC) to whom the CAC report. Matters relating to Infection Control eg:six monthly wound surveillance reports are reported to CAC. Any variances or concerns are raised with the consultants individually by the Chair. 3 monthly combined Medical Specialist meetings provide a forum for Peer review. This audit is collated and chaired by a designated Medical Specialist.

Royston Quality Committee collates a quarterly Quality Report detailing results of quality activities, overview of audits conducted including recommendations for improvement. All staff and consultants are required to participate in professional development activities. Medical staff CPD is monitored at Credentialing. Nursing staff CPD is monitored during annual PDRP with their manager.

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 of care at all times. Benchmarking of clinical KPI’s are shared within the Acuirty hospital group and nationally with private surgical hospitals via NZPSHA Benchmarking. Due to our on-going review of clinical KPI’s early detection of “clusters” or “practise alerts” trends can readily be identified and acted upon. Patient questionnaire results are monitored and any trends are evaluated by the Quality Committee. Summary of findings reported in the quarterly Quality Report. A procedure for review of hospital policies and protocols ensures current best practice is incorporated. Royston has MoH Certification and EQUiP4 Accreditation through to May 2017.
### Annual Report on Protected Quality Assurance Activities

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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:

Royston Hospital Management team monitor new clinical incidents at weekly meetings. All credentialed specialists participate in clinical audit. Clinical incidents and clinical audits are reported to Royston Clinical Advisory Committee (CAC) at monthly meetings and to Acurity Health Clinical Liaison and Advisory Committee (CLAC) to whom the CAC report. Matters relating to Infection Control eg:six monthly wound surveillance reports are reported to CAC. Any variances or concerns are raised with the consultants individually by the Chair. 3 monthly combined Medical Specialist meetings provide a forum for Peer review. This audit is collated and chaired by a designated Medical Specialist. Royston Quality Committee collates a quarterly Quality Report detailing results of quality activities, overview of audits conducted including recommendations for improvement. All staff and consultants are required to participate in professional development activities. Medical staff CPD is monitored at Credentialing. Nursing staff CPD is monitored during annual PDRP with their manager.

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 of care at all times. Benchmarking of clinical KPI's are shared within the Acurity hospital group and nationally with private surgical hospitals via NZPSHA Benchmarking. Due to our on-going review of clinical KPI's early detection of “clusters” or “practise alerts” trends can readily be identified and acted upon. Patient questionnaire results are monitored and any trends are evaluated by the Quality Committee. Summary of findings reported in the quarterly Quality Report. A procedure for review of hospital policies and protocols ensures current best practice is incorporated. Royston has MoH Certification and EQuIP4 Accreditation through to May 2017.

Please send to: Clinical Leadership, Protection and Regulation
Ministry of Health
PO Box 5013
Wellington 6145
qaa@moh.govt.nz
## Annual Report on Protected Quality Assurance Activities

<table>
<thead>
<tr>
<th>Organisation Name:</th>
<th>Southern District Health Board</th>
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<tbody>
<tr>
<td>Reporting Period:</td>
<td>January – June 2013</td>
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</table>

### 1. Name of Quality Assurance Activity

Morbidity & Mortality Review/Peer Review/Case Review

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

Numbers indicate specific groups.

1. Nil stated
2. Typing errors. Different information given for obs reporting. Under-reporting of incidental findings. Waiting list issues identified.
3. Identified need for improved interface with GPs for electronic referrals/consultations to enhance CKD management. Lack of adequate electronic database for specialty patients.
4. No major issues. We discuss clinical events and complaints.
5. Bleeding risk in PCI was discussed. Infection following pacemaker implantation was discussed.
6. The issues we had with the phacoemulsification machine for cataract surgery been resolved.
7. Code in Clinical Audit not appropriate and meaningful data not able to be extracted. DVT prophylaxis has been developed based on the national guidelines and this will be audited through the audit programme.
8. Lack of integrated IT platform for DHB.
9. A. Current method of securing lines not utilising sterile product. B. Avoids repeated heel prick tests for capillary sampling. C. Drugs being absorbed in the giving set and not delivery appropriate chartered concentration.
10. Discograms with headache due to CSF leak. Indications for discogram discussed and refined. Access to digital radiology (public and private) templating off private films. Transfer of acute patients from Invercargill for surgery and investigations. Orthopaedic patients on HDU.
11. Timely management of lab/X-ray results with shift work workforce and recent change of lab result format.
12. A. Appropriateness of surgery and anaesthesia for patients with poor quality of life and short life expectancy due to terminal disease (orthopaedic and vascular patients). B. Post-operative over sedation/respiratory depression due to multiple analgesics and different routes in a complex pain patient on the ward. C. Spinal cord ischaemia and paraplegia following hip fracture surgery under spinal anaesthetic in a patient with unknown spinal cord stenosis and late reporting of persistent motor block.
**b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:**

<p>| | |</p>
<table>
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<tr>
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<tbody>
<tr>
<td>1.</td>
<td>Nil noted.</td>
</tr>
<tr>
<td>2.</td>
<td>All cases corrected. Change in reporting style.</td>
</tr>
<tr>
<td>3.</td>
<td>Electronic referral and education tool developed in conjunction with BPAC.</td>
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<tr>
<td>4.</td>
<td>An audit of outpatient letters using a validated instrument is being conducted.</td>
</tr>
<tr>
<td>5.</td>
<td>Review of anticoagulation comparing heparin and enoxaparin has been undertaken. An investigation by Infection Prevention &amp; Control of pacemaker procedures has been commenced.</td>
</tr>
<tr>
<td>6.</td>
<td>The clinical team and procurement have worked with the supplier to resolve the problems.</td>
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<tr>
<td>7.</td>
<td>Discussions ongoing to sort plastic codes.</td>
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<tr>
<td>8.</td>
<td>None.</td>
</tr>
<tr>
<td>10.</td>
<td>Discussion planned with Southland surgeons at Oysterpod meeting. Memo to Ward. Clarification of notification and expectations of orthopaedic team to review patients.</td>
</tr>
<tr>
<td>11.</td>
<td>All acute results to be recorded/dated/timed. Results returning after discharge – record on EDIS notes including that patient or GP contacted.</td>
</tr>
<tr>
<td>12.</td>
<td>A. Review case by case; liaison with surgeons and patient/family is important; seems to be a problem mostly in acute vascular surgery patients. B. Not administering opiates via different routes concurrently, HDU or ICU care for patients with difficult to control pain, adequate handover of difficult pain patients between anaesthetic staff, adequacy of monitoring discussed with nurse in charge. C. This critical event is still under investigation. Following department review the relationship between spinal cord ischaemia and spinal anaesthesia in patient with spinal stenosis was perceived to be unclear as there are probably many other contributing factors. After extensive discussion it was felt that this isolated case should not lead to spinal anaesthesia being avoided in elderly patients with possible unknown spinal stenosis. Future recording and handover when the spinal effect is expected to have worn off by the anaesthetists was decided as a measure to enable earlier diagnosis.</td>
</tr>
</tbody>
</table>
c) List what recommendations have been (or are to be) made as a result of the activity:

1. Nil noted.
2. More rational waiting list data.
3. Approval and separate e-mail address for referrals. Acknowledgement of the external review, action on the key points of the review. Maximise patient safety and best outcomes for DHB.
4. Nil noted.
5. Nil noted.
6. Nil noted.
7. Nil noted.
8. Nil noted.
9. Nil noted.
10. Nil noted.
11. Nil noted.
12. A. Nil noted. B. Nil noted. C. The whole management of this case is going to be reviewed and external opinion is being sought for advice on future recommendations to manage these patients.

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

Monitoring will occur through the Chief Medical Officer & the Medical Director of Patient Services.

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:

Improvements that are identified through the PQAA process are driven through the Medical Directors and the Credentialing Committee.

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

The PQAA process ensures open and robust review of clinical practice and of our systems and processes.
### Annual Report on Protected Quality Assurance Activities

**June 2012**

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<tr>
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<tr>
<td>Reporting Period:</td>
<td>January - June 2012</td>
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<table>
<thead>
<tr>
<th>Name of Quality Assurance Activity</th>
<th>Morbidity/Mortality review</th>
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<tr>
<td></td>
<td>Peer Review</td>
</tr>
<tr>
<td></td>
<td>Case Review</td>
</tr>
</tbody>
</table>

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

Numbers indicate specific groups.

1. Occasional issues regarding documentation and communication are revealed. Interesting and instructive points of individual patients, their disease and its treatment discussed.
2. Nil noted.
3. No significant serious issues of a recurrent nature have emerged. Individual issues relating to a small number of complaints and adverse events have been of a sporadic nature and have been dealt with in a way agreed to be appropriate.
4. Nil noted.
5. Protocols can create problems: in case of parathyroidectomy it should be dealt with on an individual basis. Liaison with Auckland with difficult thyroid cases in pregnancy.
7. Identified the need for improved interface with GPs for electronic referrals.
9. Nil noted.
10. Difficulties attending premature births scheduled in MOT rather than in Delivery Suite which is set up for these occurrences. Caffeine is now being charted as a ‘base’ rather than ‘citrate’. Now standard practice in other NZ Neonatal Units.
11. Reviewed our infection rates and have identified no issues.
12. Nil noted.
13. 30% of Urology admissions recorded as general. Large numbers of diagnoses listed as variance after cystoscopy. Urethral injury at catheterisation for colectomy. ICU admission following infection after ESWL. Prostate infection after trans-rectal core biopsy.
14. Nil noted.
15. Nil noted.
b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

1. Identified deficiencies addressed.
2. Evidence base review of wound management.
3. Cases now recorded in book, consultants suggested diagnosis recorded and results to be audited (first analysis will be completed in 2012).
4. None.
5. No protocol to be submitted for management of hypocalcaemia post parathyroidectomy. Be aware of increased sensitivity of thyroglobulin antibodies.
6. Clarification with clinical psychologists that medical staff have responsibility for assessment indications and fitness for stress testing. A guideline has been introduced for standardising acquisition and reporting at Dunedin and Southland Hospitals.
7. Electronic referral and education tool developed in conjunction with BPAC.
8. Reiteration of importance of 'time out' and good documentation; integral part of quality and safety of care. Agreement reached with Radiology regarding after hours imaging availability. System changes regarding sterilisations discussed and implemented.
9. Nil noted.
10. Discussion and agreement with local obstetricians and anaesthetists that paediatrics will be involved in these decisions with the safety of the mother and baby being paramount. Agreement to standardise our charting to ‘base’ to ensure consistency of charting when transferring babies to other centres.
11. Circulated the DHB prophylactic antibiotic protocols – operative and post-operative.
12. Nil noted.
13. Ask OCA to mark all KPS admissions Urology. Reserve variance for unexpected diagnoses at or post—surgery, in particular if altered management. Abort trans-urethral catheterisation in any clinical scenario if not possible to place with gentle push. Consider suprapublic catheter after performing laparotomy for difficult transurethral in colectomy. Rare complication. Sound process. Consider offering DHB Antibiotic Advisory Group opinion on prophylaxis for trans-rectal biopsy.
14. Nil noted.
15. Nil noted.
c) List what recommendations have been (or are to be) made as a result of the activity:

1. Nil noted.
2. Nil noted
3. Nil noted
4. Nil noted
5. Nil noted
6. See above.
7. Approval and separate e-mail address for referrals. Acknowledgement of the external review, action on the key points of the review maximise patient safety and best outcomes for the DHB. Clinic space and rooms along with clinic bookings put into place.
8. Nil noted.
9. None.
10. Agreement fed back to the wider anaesthetic and obstetric departments.
11. Theatre environment is undergoing testing for bacterial contamination. Bone flap handling and storage protocols are being reviewed with view to minimise handling including swabbing.
12. Nil noted.
13. Nil noted.
14. Nil noted.
15. Nil noted.

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

Monitoring will occur through the Chief Medical Officer.

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:

Improvements that are identified through the PQAA process are driven through Clinical Directors, the Credentialing Committee and the Clinical Board. Where the issue relates to the performance of individuals, the performance management process is enacted and support provided from clinical leadership.

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

The PQAA process ensures open and robust review of clinical practice and of our systems and processes. The corrective actions implemented have resulted in safer systems, improved patient communication, improved interface between clinical groups and better management of resources.
### Annual Report on Protected Quality Assurance Activities

**June - December 2012**

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<tr>
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<tbody>
<tr>
<td><strong>Reporting Period:</strong></td>
<td>June - December 2012</td>
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#### 1. Name of Quality Assurance Activity

- **Morbidity/Mortality review/ Peer Review/ Case Review**

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

<table>
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<tr>
<th></th>
<th>Numbers</th>
<th>Specific Groups</th>
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<tbody>
<tr>
<td>2.</td>
<td>Lack of clarity and transparency on transfer of patients to Dunedin Hospital from referring regional hospitals.</td>
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<td>3.</td>
<td>None.</td>
<td></td>
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<td>4.</td>
<td>There have been occasions where handover of cases between anaesthetists were inadequate and certainly not consistent.</td>
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<td>5.</td>
<td>None.</td>
<td></td>
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<td>6.</td>
<td>One case of death following bronchoscopy.</td>
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<td>7.</td>
<td>Audit of grand round case review process completed. Results demonstrated clinical and educational utility of this activity. The audit will be repeated to investigate whether factors related to diagnostic category continue to be significant.</td>
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<tr>
<td>8.</td>
<td>Nil noted.</td>
<td></td>
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<td>9.</td>
<td>No system issues were identified, but there were individual learning outcomes, of which all participants took note.</td>
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<td>10.</td>
<td>Nil noted.</td>
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<td>11.</td>
<td>Nil noted.</td>
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<tr>
<td>12.</td>
<td>Identified the need for improved interface with GPs for electronic referrals / consultations to enhance CKD management.</td>
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<tr>
<td>13.</td>
<td>Nil noted.</td>
<td></td>
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<tr>
<td>14.</td>
<td>There are continuing problems with the phacoemulsification machine used in our theatre for cataract surgery.</td>
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<td>16.</td>
<td>a. Plastic codes in Clinical Audit not appropriate and this is still being worked.</td>
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<td></td>
<td>b. Audit programme has a new co-ordinator and is working very well.</td>
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<td></td>
<td>c. DVT prophylaxis guidelines require updating to meet new national guidelines.</td>
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<tr>
<td>17.</td>
<td>Delays in transfer of patients from outlying rural areas.</td>
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<tr>
<td>18.</td>
<td>a. Reviewed need for appropriate transition of care arrangements for adolescents with DMD.</td>
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<td></td>
<td>b. Reviewed need for privacy/ culturally aware environment for bereaved families in ED.</td>
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<td></td>
<td>c. Family sent copy of post-mortem findings directly. Contained opinion on cause of death not wholly supported by involved clinicians.</td>
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</tbody>
</table>
20. GP referral guidelines and grading review of referral letters. This discussion has come about because of increasing financial constraints and timing constraints with FSAs and operation access in the public system. There has also been GP complaints regarding lack of access to the Outpatients clinics. GPs seem to have an accurate idea of the restrictions to access in the Public Hospital. We have set out referral guidelines in the past for access into the public hospital and these have been reiterated in 2012.

A. The anticoagulation and operations was discussed with specially the use of Clopidogrel and Dabigatran.

B. Review of analgesic protocol in the department was performed for our junior staff. We also had a discussion regarding Oxycodone and OxyNorm use in ENT patients. The protocols have been updated and distributed to junior staff.

C. The need for Head & Neck cancer patients to be reviewed in the Combined Head & Neck Oncology clinic is essential for standard of care Head & Neck practice. This came about due to a delay in access to clinic which was reviewed during audit.

D. Sound decision making for use of and ordering investigations was discussed. The role of ultrasound monitoring in thyroid should be limited. If access to the Radiology Department for Head & Neck cancer patients has been discussed and a letter sent to Head of Radiology Department. This letter is enclosed in the report.

E. The role of sleep study in paediatric adenotonsillectomy patients. By and large we feel that unless the diagnosis is uncertain or severe OSA is likely then a sleep study is not required routinely for paediatric tonsil patients.

F. Surgical techniques in lower lip reconstruction following skin cancer removal was discussed throughout the year.

Note was made of some significant discussions. These included bleeding tonsils, skin lesion excision margins, velopalatal insufficiency post-adenotonsillectomy, otoplasty and skin necrosis, chylous fistular formation post-neck dissection, airway obstruction post paediatric adenotonsillectomy, arytenoid dislocation post-emergency intubation was also discussed.

The number of cancelled lists was a major issue in 2012. There is ongoing discussion regarding list cancellations for 2013 and we are endeavouring to minimise our cancellation rate with ongoing discussion with the management.
b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

1. Advice to junior and SMO staff in the rational use of opiates. Seek a balanced exposure to both well and inpatient elderly for student’s professional training needs. Engage the future advanced trainee(s) in evaluating best practice approaches to bladder dysfunction and management.
2. Development of inter-hospital transfer board and cath lab whiteboard. This has improved communication and addressed problems with referrals being lost from the system.
3. Nil noted.
4. Discussion about what needs to happen and the best way to handover. A small ad-hoc committee was formed and came up with a handover template which everyone agreed to.
5. Nil noted.
6. Improved information collection relating to bronchoscopies, particularly adverse events and outcomes.
7. Nil noted.
8. Nil noted.
9. Nil noted.
10. Nil noted.
11. Nil noted.
12. Nil Noted.
13. None.
14. The problems have been highlighted with the company supplying the machine, who have made multiple visits and adjustments to settings. There has been communication with our procurement Department, who are trying to resolve this issue with the supplying company. We are seeing too many complications relating directly to this machine, e.g. corneal wound burns.
15. Standardised analgesic pathway developed. Recall system in place. Discussion with anaesthesia, ICU, Pain team to improve protocols on transition day.
16. a. Discussions with co-ordinator of audit to sort codes and OCA.
   b. Reports are sent to all consultants re ordinary number of sessions attended.
   c. Development of new guideline with Southland surgeons with implementation date of 4 March.
17. Transfer of patients from outlying rural areas which has caused delays have been discussed.
18. a. Nil Team reminded to use best practice clinical management guidelines, plan transition.
   b. Discussed with ED team at interface meeting.
   c. To discuss with coroner.
20. Nil noted.
c) List what recommendations have been (or are to be) made as a result of the activity:

1. Nil noted.
2. Nil noted
3. Nil noted
4. Handover template in large print posted in every Operating Theatre site to encourage standardised and adequate handover details are passed on.
5. Nil noted.
6. Nil noted.
7. Nil noted.
8. Nil noted.
9. Nil noted.
10. Nil noted.
11. Nil noted.
12. a. Approval and separate e-mail address for referrals.
   b. Acknowledgement of the external review, action on the key points of the review maximize patient safety and best outcomes for the DHB.
   c. Still awaiting definitive action.
13. Nil noted.
14. Procurement staff are working to try and resolve this issue, but we are concerned about the Ongoing risk to patients and to the organisation.
15. Nil noted.
16. Nil noted.
17. Nil noted.
18. Nil noted.
19. Nil noted.
20. Nil noted.

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

Monitoring will occur through the Medical Director of Patient Services and Chief Medical Officer

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:

Improvements that are identified through the PQAA process are driven through Medical Directors, the Credentialing Committee and the Clinical Board. Where the issue relates to the performance of individuals, the performance management process is enacted and support provided from clinical leadership.

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

The PQAA process ensures open and robust review of clinical practice and of our systems and processes. The corrective actions implemented have resulted in safer systems, improved patient communication, improved interface between clinical groups and better management of resources.
Please send to: Sandra Cumming  
Ministry of Health  
PO Box 5013  
Wellington
Annual Report on Protected Quality Assurance Activities

| Organisation Name: | University of Otago  
Women’s Health Research Centre |
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<tr>
<td>Reporting Period:</td>
<td>Annual report due September 2012</td>
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</tbody>
</table>

1. Name of Quality Assurance Activity

SAMM audit – Assessing Severe Acute Maternal Morbidity: A review of four District Health Boards

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

No issues have been identified in the process of audit in the course of the study. Issues arising from review of cases has shown that 40% of cases were deemed by expert panel to be potentially preventable.

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

Issues arising from the identification of preventable severe maternal morbidity have been addressed in the report to the Ministry of Health and the paper submitted for publication. A report is currently with the Ministry of Health with the results of the first 80 cases of audit and the potential preventability of cases as well as recurring themes which can be used to develop educational and other interventions to improve care. We have also submitted for peer review publication a paper which has anonymised and collated results of the audit to assist all registered health practitioners involved in the provision of maternity care to improve their services to their patients.

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

Themes of preventability have been identified and the results of the audit have been reported to the MOH and a paper will shortly be submitted for publication in a peer reviewed journal. The recommendations in this report and paper focus on training and education for health practitioners in improved management of post-partum haemorrhage and recognition of septicaemia in the pregnant woman. Action will be taken by further dissemination of these results occurring in collaboration with professional colleges looking at education measures and training which can be incorporated into current training for health practitioners involved in maternity care.
d) Describe how implementation of these recommendations will be monitored:

Funding has been secured to take the next step in expanding this process to a national audit. This means that a quality cycle can be implemented and improvement in care can be actively monitored by the continuing audit and analysis of SAMM cases on a national basis. For example, once awareness has been raised and education on themes has been instigated, review of cases of SAMM will identify whether this has been successful or not by analysing the causes, outcomes and rates of severe maternal morbidity on an ongoing basis.

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 process of audit is continually reviewed by our staff to ensure confidentiality. The research staff are guided by the ethical approval process and the university of Otago policies.

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

The public interest is best served by in depth analysis of the results of health care, with participation of all involved health practitioners. The framework being used by the panel to decide whether the standard of care was being met or not, is different from those used in other decisions on the standard of care, especially those decisions within the legal sphere, and thus the decisions are open to misuse if not protected. Protection has assisted in ensuring that all practitioners are able to participate freely. This has been acknowledged by participants as an important factor in the ability to come to unbiased decisions on cases reviewed. The immediate effect of the process on the expert panel members has been self-reported changes in clinical knowledge and practice, changes in teaching of students and trainees and mentoring of junior staff. This has been reported as a “ripple” effect by all participants in the audit process- obstetricians, anaesthetists, intensivists and midwives. Therefore, both the short term effects and long term effects of improved awareness, education and improved monitoring of severe maternal morbidity will benefit pregnant women, and their infants by improving outcomes and reducing the severity of morbidity experienced by women during pregnancy.

Please send to: Clinical Leadership, Protection and Regulation
Ministry of Health
PO Box 5013
Wellington 6145
qaa@moh.govt.nz
Health Practitioners Quality Assurance Activity: Taranaki District Health Board

Annual Report to: Minister of Health

From: Anne Kemp (Responsible Person under the Taranaki DHB Notice 2009)

Report Period: 13 November 2012 to 12 November 2013

Report Prepared By: Anne Kemp
Quality & Risk Manager
Taranaki DHB
3 January 2014
Reporting Arrangements (Responsible Person)
This is the fourth annual report from the Responsible Person (Anne Kemp) to the Minister of Health. Reports have also been submitted six monthly to the Taranaki DHB in accordance with the requirements of the Health Practitioners Competence Assurance Act.

Protected Quality Assurance Activities Currently Registered at Taranaki DHB
The Quality Assurance Activities (QAA) which are currently protected under the Health Practitioners (Quality Assurance Activity – Taranaki DHB) Notice are set out in Appendix 1.

QAA, for which protection is sought under the Taranaki DHB Notice, must be registered with the Responsible Person before the commencement of the activity. There have been three new registrations and one registered activity that have ceased during the reporting period.

Compilation of the Report: Method
The Responsible Person requests a six monthly report on PQAA activities from each of the Overseers for the periods ending 12 May 2013 and 12 November 2013. Following receipt of the reports, the Responsible Person, if required, discusses the registered activity with the Overseer who has reported a new problem/issue or for whom problems or issues remain unresolved at the time of the last report. The Responsible Person prepares a draft report to Taranaki DHB for each of the six month periods with the draft report being submitted to the Taranaki DHB Chief Operating Officer for comment. There were no areas of disagreement between the Responsible Person and Management.

As in previous reports, the criterion used for a “problem or issue” identified in the course of PQAA is that the clinical group undertaking PQAA activity have perceived the matter to be a “problem or issue”.

The same system of numbering of the problems/issues identified in the course of PQAA that was first introduced in the reports to the Taranaki DHB and the Minister of Health for the period ending 22 January 2007 has been used in this report. The purpose is to facilitate the tracking of outstanding problems/issues from one report to the next.
Annual Report on Protected Quality Assurance Activities

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<tr>
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<tbody>
<tr>
<td>Reporting Period:</td>
<td>13 November 2012 to 12 November 2013</td>
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</table>

1. Name of Quality Assurance Activity

1. Multidisciplinary Morbidity, Mortality and Improvement Meeting (MMMI)
2. Obstetrics and Gynaecology

While the following are QAA registered under the Taranaki DHB PQAA Notice and QAA may be invoked for the whole or part of the meetings, they have either not considered this necessary or there have been no new issues over the period of this report.

- Emergency Department
- Fulford Radiology
- Obstetrics & Gynaecology
- Orthopaedics
- Surgery Morbidity and Mortality meetings, annual specialty directed audit projects, vascular audit data and risk adjusted POSSUM data.
- Taranaki DHB Diabetes Services Team meetings
- Taranaki DHB Clinical Board
- Taranaki Lab staff seminars
a) List any problems or issues that have been identified in the course of the activity:

**Multidisciplinary Morbidity, Mortality and Improvement Meeting (MMMI)**

1a. (Ref. 2010/2/2). Plan of care for complex patients to be kept in electronic form on the patient management system.

1b. (Ref. 2010/2/8). Implementation of an Early Warning System (EWS) in Emergency Departments.

1c. (Ref. 2010/2/9). Establishment of ethical principles of shared care within the Taranaki DHB.

1d. (Ref. 2011/1/1b). Delineate notification pathway about the dates of MMMI meetings to allow the hospital wide spread of information and planning for the event (including the creation of a web page).

1e. (Ref. 2011/1/3). Time conflict of medication administration to the patients with other nursing tasks (participation in ward rounds, shift handover etc).

1f. (Ref. 2011/1/4). Improved junior medical staff hand over on-call, including electronic support and full discussion of complex cases.

1g. (Ref. 2011/1/6). Better management of allergies and adverse reactions to medication through the introduction of the national adult medication chart and the improvement of our electronic database.

1h. (Ref. 2011/2/1). Encourage direct consultant to consultant communication, especially in difficult or complex cases.

1i. (Ref. 2011/2/5). Management of the morbidly obese patient.

1j. (Ref. 2012/2/1). Establish therapeutic goals and limitations to treatment.

1k. (Ref. 2012/2/2). Recognition that the current High Dependency Unit (HDU) model is ‘open HDU’ and has issues that need to be addressed.

1l. (Ref. 2013/1/1). Documenting initial findings found during the physical examination.

1m. (Ref. 2013/1/2). Assessment of the deteriorating patient and early warning score and system.

1n. (Ref. 2013/1/3). Inter-hospital transport by aircraft and requirements.

10. (Ref. 2013/1/4). Influenza vaccination.

**Obstetrics and Gynaecology**

2b. (Ref. 2011/2/6) Low uptake of post mortems.

2c. (Ref. 2011/2/7) Lack of drug testing when a neonatal death occurs due to the need for informed parental consent.
List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

<table>
<thead>
<tr>
<th>Multidisciplinary Morbidity, Mortality and Improvement Meeting (MMMI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1a.</strong> (Ref. 2010/2/2). Advanced Directives and 'allow natural death' / not for CPR policy has been developed and implemented. The new IT portal (Concerto) has been implemented, however with the migration of our acute service wards to their new building in August 2013, the focus has been on addressing IT needs that have not included electronic care planning for complex patients to date. <strong>Progressing.</strong></td>
</tr>
<tr>
<td><strong>1b.</strong> (Ref. 2010/2/8). Progress has been made whereby the initial EWS score is completed prior to discharge from ED and an admission EWS is required upon arrival to the ward. <strong>Issue resolved.</strong></td>
</tr>
<tr>
<td><strong>1c.</strong> (Ref. 2010/2/9). The pilot discussion between ICU and Dept of Medicine has occurred and basic ethical principles of shared care agreed upon. Feedback about these principles has been reviewed but has not progressed to discussion by the Head of Departments or the Clinical Board for endorsement. <strong>Progressing.</strong></td>
</tr>
<tr>
<td><strong>1d.</strong> (Ref. 2011/1/1b). The MMMI are now under the auspices of the Mortality and Morbidity Review Committee. Administrative support has been obtained and notification pathways developed. Development of the web page remains in progress <strong>Progressing.</strong></td>
</tr>
<tr>
<td><strong>1e.</strong> (Ref. 2011/1/3). This is being worked through projects related to Releasing Time to Care, Models of Care now operating in the new Taranaki Base Hospital facility and the e-Pharmacy projects whereby electronic prescribing (currently in one ward) will expand to other wards in 2014. <strong>Remains in progress.</strong></td>
</tr>
<tr>
<td><strong>1f.</strong> (Ref. 2011/1/4). The consideration of developing and introducing an inpatient classification system based on complexity (similar to ASA classification) is in progress. The electronic support for hand over has been implemented and working well. <strong>Progressing.</strong></td>
</tr>
<tr>
<td><strong>1g.</strong> (Ref. 2011/1/6). The introduction of the national adult paper medication chart across all inpatient wards while scheduled for implementation in 2013 has not occurred due to issues encountered beyond the DHB’s control. Implementation is now set for the week beginning the 10 February 2014. Implementation of e-prescribing beyond the one trial ward has not progressed as planned but expect to roll this out further once IT software issues are resolved early in 2014. Paper and electronic medicine reconciliation has been implemented in most of the DHB’s clinical wards/areas. <strong>Progressing.</strong></td>
</tr>
<tr>
<td><strong>1h.</strong> (Ref. 2011/2/1). Some technical communication issues have been identified with the migration of our acute wards to their new building particularly poor cell phone reception earlier this year. <strong>Remains in progress.</strong></td>
</tr>
<tr>
<td><strong>1i.</strong> (Ref. 2011/2/5). A multi-disciplinary group continues to provide leadership in the management of the bariatric patient. <strong>Issue closed.</strong></td>
</tr>
<tr>
<td><strong>1j.</strong> (Ref. 2012/2/1). Increased awareness of establishing therapeutic goals and limitations to treatment has been achieved. This is supported by the Chief Medical Advisor. <strong>Remains in progress.</strong></td>
</tr>
<tr>
<td><strong>1k.</strong> (Ref. 2012/2/2). The responsibility for a HDU patient’s admission, care and discharge is with the primary team with the intensive care team becoming involved only after a referral with the amount of requirement involvement clarified at the time of referral. Need to address the management of demands on HDU beds when the HDU is full and ensure effective communication of treatment plans and limitations on care of HDU patients to on call teams. <strong>Remains in progress.</strong></td>
</tr>
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<td><strong>1l.</strong> (Ref. 2013/1/1). The importance of documenting initial findings from the physical examination has been raised and emphasised. <strong>Issue resolved.</strong></td>
</tr>
<tr>
<td><strong>1m.</strong> (Ref. 2013/1/2). This issue has been discussed with medical staff in regard to setting criteria and pathways for escalation to more senior medical staff. EWS education for nurses includes criteria review and escalation pathways. <strong>Issue resolved.</strong></td>
</tr>
<tr>
<td><strong>1n.</strong> (Ref. 2013/1/3). The essential need for an adequate handover has been raised and emphasised along with raising awareness of the DHB medical flight team structure. <strong>Issue resolved.</strong></td>
</tr>
<tr>
<td><strong>1o.</strong> (Ref. 2013/1/4). The risks and benefits of influenza vaccination discussed and the importance of staff vaccination emphasised. <strong>Issue resolved.</strong></td>
</tr>
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</table>
**Obstetrics and Gynaecology**

2b. (Ref. 2011/2/6) Continue to seek informed consent from parents and project the positive side of post mortem on a still born baby. Aim to get the post mortem results through as quickly as possible. All Lead Maternity Carers, Paediatric and Obstetric Consultants are aware. **Resolved to an acceptable level.**

2c. (Ref. 2011/2/7) Continue to wait for a national policy on testing and advice over issue of consent. **Remains in progress.**

---

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

See b) above for the recommendations/actions described under each individual issue.

---

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

**Multidisciplinary Morbidity, Mortality and Improvement Meeting (MMMI)**

- One of the chairs of the MMMI meeting performs an overarching monitoring function and provides regular updates on agreed actions/recommendations.
- Some specific actions/recommendations sit with specific projects for implementation/monitoring eg Releasing Time to Care, e-Pharmacy or specific committees eg Regional Trauma Committee, Heads of Department, Clinical Board.

**Obstetrics and Gynaecology**

- Monitoring is assigned to the appropriate meeting/committee eg Perinatal, Obstetric and Gynaecology Mortality meeting and/or Maternity Quality Committee.
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:

On behalf of the Chief Executive, the Taranaki DHB Clinical Board has the purpose of:

- Ensuring that the DHB has appropriate systems in place for good quality clinical practice that are equitable and mechanisms for ongoing learning and improvement.
- Being mindful of the context and environment within which the services of the Taranaki DHB operate, including legislation and resources.

The primary roles of the Clinical Board are to:

- Oversee the process of development, sign off, review, implementation and compliance monitoring of organisation wide clinical policies and guidelines.
- Oversee the function of clinical committees throughout the Taranaki DHB including receiving annual reports from each provider-arm committee.
- Receive an annual report via the Chief Medical Advisor from each clinical hospital and specialist services of the Taranaki DHB.
- Receive direct input from clinician or consumer committees or representatives when necessary.
- Give advice on matters that have not been successfully resolved through normal clinical management processes.
- Take a leadership role in the quality and risk programme as related to clinical matters including but not limited to reportable events, clinical risks.
- Receive the results/recommendations from all external quality/risk audits and reports undertaken in the hospital and specialist services and monitor the implementation of the resulting action plans.
- Learn from the experience of others eg HDC reports
- Promote the development of primary-secondary interface and co-operation between clinical services in the primary and secondary sectors.
- Promote collaborative clinical projects at a clinical level between primary and secondary sectors.
- Promote improvement in clinical practice through the commissioning of specific investigations of particular clinical issues, policies, any unresolved clinical safety issues or any matter arising out the Clinical Board’s monitoring role, and to make recommendations to appropriate groups or individuals.
- Provide clinical advice to senior management, the Executive Management Team, Chief Executive, and through the Chief Executive to the Taranaki District Health Board.
- Encourage all individual staff members to seek out examples of good clinical practice, to review these and encourage their introduction to the Taranaki DHB as appropriate.
- Receive advice about research projects involving hospital and community based services.
- Provide advice to the Taranaki DHB on clinical governance issues.
- Provide a written summary report of activities, progress and plans on a six monthly basis to the Chief Executive.
- Facilitate the development of a local Taranaki Clinical Ethics Advisory Group.

Taranaki DHB acknowledges that there is a shared responsibility to ensure clinical practitioners are competent to work in their particular clinical setting. Credentialling is a tool for clinical practitioners to demonstrate that they have the knowledge, skill and organisational support to provide safe and effective clinical care to patients. It is part of a wider organisational quality and risk management system designed primarily to protect the patient. While the Credentialling Policy is intended to be an all encompassing policy, the emphasis is on senior medical staff credentialling. Over time, the aim is to develop credentialling programmes for other health professionals working at a senior level, or those with an expanded or extended scope of practice.
**f) Summarise the benefits to the health and disability consumers resulting from the activities described in this report:**

Significant problems/issues that affect the quality of care of consumers continue to be identified in the course of PQAA. They seldom involve the competence or behaviour of health professionals but more frequently tend to concern policies, systems and processes in the Taranaki DHB. No significant problems/issues regarding the competence of individual health practitioners have been identified in courses of the PQAA process in the period of this report.

As stated in previous reports, only problems/issues that have been identified in connection with PQAA are included in the reports of the Responsible Person to the Taranaki DHB. Thus, in view of the widespread conduct of QAA outside of the Notice it is important and in the interest of consumers for Taranaki DHB to maintain a robust system to ensure that clinically important problems/issues which are identified as a result of non-protected QAA are notified and escalated as appropriate via the line management structure of the Taranaki DHB.

Benefits to health and disability consumers from quality improvement activities outlined in this report include:

- Faster and better co-ordinated care.
- Increased patient safety.
- Patients with major trauma are transferred to the hospital offering definitive care.
- Increased and improved communication between specialities that improves patient care and safety.
- Increased and improved handover communication that improves patient care.
- Utilising technology to reduce error and patient adverse events.
- Seeking out best practice and then standardising treatment pathways and equipment to be utilised.

Please send to: Clinical Leadership, Protection and Regulation
Ministry of Health
PO Box 5013
Wellington 6145
[qaa@moh.govt.nz](mailto:qaa@moh.govt.nz)

**APPENDIX 1**
Quality Assurance Activities protected under the Health Practitioners (Quality Assurance Activity: Taranaki District Health Board) Notice 2009 as at 12 November 2013

**Department:** Surgery

**Date PQAA Registered:** 1 April 2005  
**Re-registered:** 13 November 2009

**Protected QAA:**
- Morbidity and Mortality meetings (weekly).
- Annual specialty directed audit projects.
- Vascular audit data.
- Risk adjustment POSSUM data.

**Department:** Corporate

**Date PQAA Registered:** 7 March 2005  
**Re-registered:** 13 November 2009

**Protected QAA:**
- Clinical Board meetings: Clinical Board oversees audit and audit processes within Taranaki DHB.

(Note: Specific sections of the meeting of the Clinical Board will be designated as PQAA activity when necessary and the records for that section of the meeting will be handled in accordance with Taranaki DHB policy for PQAA).

**Department:** Obstetrics & Gynaecology

**Date PQAA Registered:** 15 February 2005  
**Re-registered:** 13 November 2009

**Protected QAA:**
- Three monthly Perinatal Meeting.
- Gynaecology Morbidity and Mortality Meeting. (Registered 6 May 2010)
- Maternity Quality Committee Meeting (Registered 13 December 2012)
- Weekly Obstetric Outcome Meeting (Registered 13 December 2012)

**Department:** Radiology

**Date PQAA Registered:** 14 December 2004  
**Re-registered:** 13 November 2009

**Protected QAA:**
- Case Review Audit: Any known cases of ‘error’ in interpretation of a radiological study/investigation are recorded in a book. Such cases are reviewed quarterly at a formal audit meeting led by the Clinical Director and attended by all radiologists. The Clinical Director summarises the cases reviewed in written form.

**Department:** Orthopaedics

**Date PQAA Registered:** 18 June 2008  
**Re-registered:** 13 November 2009

**Protected QAA:**
- Orthopaedic Department Clinical Audit Meetings and Peer Review Meetings.
- National Joint Registry Data Collection. Conducted routinely in theatre, and the analysis of such data conducted by the Registry.
Department: Labcare Pathology (on behalf of Taranaki DHB Diabetes Service Team)

Date PQAA Registered: 19 June 2006  Re-registered: 13 November 2009

Protected QAA:

- Taranaki DHB Diabetes Service: The Taranaki DHB Diabetes Service Team meets monthly and as part of the meeting the group may discuss case studies and best practice issues. The Overseer will take responsibility for ensuring that the discussion has QAA protection when appropriate.

Department: Labcare Pathology

Date PQAA Registered: 19 June 2006  Re-registered: 13 November 2010

Protected QAA:

- Taranaki Seminars: Laboratory staff meet three times per year at the Taranaki Seminars to attend sessions for their Continuing Professional Development. The intention is to have presentations on specific topics and also include some case studies. The Overseer will take responsibility for ensuring that the discussion has QAA protection when appropriate.

Department: Hospital-wide

Date PQAA Registered: 13 November 2009

Protected QAA:

- Multi-disciplinary Morbidity, Mortality and Improvement meetings. Meetings are held three times a year and involve staff from across the organisation.
- Mortality and Morbidity Review Committee Meeting. (Registered 20 August 2013)

Department: Taranaki Base Hospital Emergency Department

Date PQAA Registered: 5 June 2007  Re-registered: 13 November 2010

Protected QAA:

- Bi-Monthly Taranaki Base Hospital ED Morbidity and Mortality Meeting
- Monthly Taranaki Base Hospital Emergency Medical Staff Meetings

Department: Hawera Hospital

Date PQAA Registered: 31 August 2007  Re-registered: 13 November 2010

Protected QAA:

- Hawera Hospital Clinical Services Management meeting, formally the bi-monthly Hawera Hospital Emergency Clinical Review meeting originally registered on 28\textsuperscript{th} January 2005.
Health Practitioners Quality Assurance Activity: Taranaki District Health Board

Annual Report to:  Minister of Health

From:  Anne Kemp (Responsible Person under the Taranaki DHB Notice 2009)

Report Period:  13 November 2011 to 12 November 2012

Report Prepared By:  Anne Kemp
                     Quality & Risk Manager
                     Taranaki DHB
                     31 December 2012

Signed:______________________    Date: _____________
Reporting Arrangements (Responsible Person)
This is the third annual report from the Responsible Person (Anne Kemp) to the Minister of Health. Reports have also been submitted six monthly to the Taranaki DHB in accordance with the requirements of the Health Practitioners Competence Assurance Act.

Protected Quality Assurance Activities Currently Registered at Taranaki DHB
The Quality Assurance Activities (QAA) which are currently protected under the Health Practitioners (Quality Assurance Activity – Taranaki DHB) Notice are set out in Appendix 1.

QAA for which protection is sought under the Taranaki DHB Notice must be registered with the Responsible Person before the commencement of the activity. There have been no new registrations and no registered activities have ceased during the report period.

Compilation of the Report: Method
The Responsible Person requested a six monthly report on PQAA activities from each of the Overseers for the periods ending 12 May 2012 and 12 November 2012. Following receipt of the reports, the Responsible Person, if required, discussed the registered activity with the Overseer who had reported a new problem/issue or for whom problems or issues remained unresolved at the time of the last report. The Responsible Person prepared a draft report to Taranaki DHB for each of the six month periods and the drafts were submitted to the Taranaki DHB General Manager Hospital and Specialist Services, for comment. There were no areas of disagreement between the Responsible Person and Management.

As in previous reports, the criterion used for a “problem or issue” identified in the course of PQAA is that the clinical group undertaking PQAA activity have perceived the matter to be a “problem or issue”.

The same system of numbering of the problems/issues identified in the course of PQAA that was first introduced in the reports to the Taranaki DHB and the Minister of Health for the period ending 22 January 2007 has been used in this report. The purpose is to facilitate the tracking of outstanding problems/issues from one report to the next.
Annual Report on Protected Quality Assurance Activities

Organisation Name: Taranaki District Health Board
Reporting Period: 13 November 2011 to 12 November 2012

1. Name of Quality Assurance Activity

1. Emergency Department
2. Multidisciplinary Morbidity, Mortality and Improvement Meeting (MMMI)
3. Obstetrics and Gynaecology

While the following are QAA registered under the Taranaki DHB PQAA Notice and QAA may be invoked for the whole or part of the meetings, they have either not considered this necessary or there have been no new issues over the period of this report.

- Emergency Department
- Fulford Radiology
- Orthopaedics
- Primary Response in Medical Emergency (PRIME)
- Surgery Morbidity and Mortality meetings, annual specialty directed audit projects, vascular audit data and risk adjusted POSSUM data.
- Taranaki DHB Diabetes Services Team meetings
- Taranaki DHB Clinical Board
- Taranaki Lab staff seminars
a) List any problems or issues that have been identified in the course of the activity:

### Emergency Department

1a. (Ref. 2005/2/4) Failure to meet standards for waiting time for triage categories 2 and 3 in the Emergency Department

### Multidisciplinary Morbidity, Mortality and Improvement Meeting (MMMI)

2a. (Ref. 2010/2/2) Plan of care for complex patients to be kept in electronic form on the patient management system.
2b. (Ref. 2010/2/7) Issues of direct transport of selected trauma patients bypassing Hawera Hospital.
2c. (Ref. 2010/2/8) Implementation of an Early Warning System in Emergency Departments.
2d. (Ref. 2010/2/9) Establishment of ethical principles of shared care within the Taranaki DHB.
2e. (Ref. 2011/1/1b) Delineate notification pathway about the dates of MMMI meetings to allow the hospital wide spread of information and planning for the event (including the creation of a web page)
2f. (Ref. 2011/1/3) Time conflict of medication administration to the patients with other nursing tasks (participation in ward rounds, shift handover etc).
2g. (Ref. 2011/1/4) Improved junior medical staff hand over on-call, including electronic support and full discussion of complex cases.
2h. (Ref. 2011/1/6) Better management of allergies and adverse reactions to medication through the introduction of the national adult medication chart and the improvement of our electronic database.
2i. (Ref. 2011/2/1) Encourage direct consultant to consultant communication, especially in difficult or complex cases.
2j. (Ref. 2011/2/4) Ethical consideration as to what is defined as ‘terminal management’.
2k. (Ref. 2011/2/5) Management of the morbidly obese patient.
2l. (Ref. 2012/2/1) Establish therapeutic goals and limitations to treatment.
2m. (Ref. 2012/2/2) Recognition that the current High Dependency Unit (HDU) model is ‘open HDU’ and has issues that need to be addressed

### Obstetrics and Gynaecology

3a. (Ref. 2011/1/7) Obtaining best quality post mortems on stillborn babies.
3b. (Ref. 2011/2/6) Low uptake of post mortems.
3c. (Ref. 2011/2/7) Lack of drug testing when a neonatal death occurs due to the need for informed parental consent.
b) List what actions have been taken, as a result of the activity, to resolve the identified problems/issues:

**Emergency Department**

1a. (Ref. 2005/2/4) This is an ongoing issue. In consultation with the ED PQAA Overseer, this issue has been removed from the PQAA list and placed into the ED Risk Register for future monitoring and management. **Issue removed.**

**Multidisciplinary Morbidity, Mortality and Improvement Meeting (MMMI)**

2a. (Ref. 2010/2/2) Advanced Directives and ‘allow natural death’ / not for CPR policy has been developed and implemented. We are currently implementing a new IT portal (Concerto) where we expect to have at some point electronic plans of care for complex patients. **Progressing.**

2b. (Ref. 2010/2/7) Input from the Medical Director of St John Ambulance obtained. The final report from the Regional Trauma Co-ordinator received as part of a sentinel event review and recommendations issued. Credentialling review of the Hawera Rural Hospital Services finalised and recommendations regarding ‘trauma bypass’ issued. Policy addressing transfer to point of definitive care for patients with major trauma in South Taranaki adopted by the Clinical Board in October 2012. Initial series of mock trauma scenarios and teaching sessions held in Hawera Hospital with Taranaki Base and Hawera Hospital staff participating. **Resolved**

2c. (Ref. 2010/2/8) Raised with ED staff but no significant progress has been made. **Issue remains in progress.**

2d. (Ref. 2010/2/9) The pilot discussion between ICU and Dept of Medicine has occurred and basic ethical principles of shared care agreed upon. Feedback about these principles to be reviewed at the second meeting and then presented to the Head of Departments meeting and later to the Clinical Board for endorsement. **Progressing.**

2e. (Ref. 2011/1/1b) Web page creation remains in progress. **Progressing.**

2f. (Ref. 2011/1/3) This is being worked through projects related to Releasing Time to Care, Models of Care for the new Taranaki Base Hospital facility and the e-Pharmacy projects. **Remains in progress.**

2g. (Ref. 2011/1/4) The consideration of developing and introducing an inpatient classification system based on complexity (similar to ASA classification) is in progress as is the electronic support for hand over allowing easier reference. **Progressing.**

2h. (Ref. 2011/1/6) The introduction of the national adult paper medication chart has not been actioned to date due to the e-Pharmacy project activity that includes e-prescribing, e-reconciliation and better management of patient allergies and adverse reactions. However in 2013, we expect to introduce the national adult paper medication chart in other inpatient areas not affected by the clinical services new build eg maternity. **Remains in progress.**

2i. (Ref. 2011/2/1) Communication workshop targeting all staff working in the operating theatres has taken place. As well, use of cell phones in emergency situations, referrals supported by notation in the patient’s clinical record by the referring and accepting teams, and encouraging junior staff to remain involved in the referral process has been communicated. The principles of Shared Care have been raised at Heads of Department meetings and Clinical Board. **Remains in progress.**

2j. (Ref. 2011/2/4) The Taranaki DHB’s Clinical Ethics Advisory Group has been formed, is functional and providing assistance/advice to clinicians. The Advanced Directives and ‘allow natural death’ / Not for CPR policy has been developed and implemented. **Resolved.**

2k. (Ref. 2011/2/5) A multi-disciplinary group has been formed and is developing models of acute and elective care for morbidly obese patients. Some of the equipment recommendations have been actioned. **Remains in progress.**

2l. (Ref. 2012/2/1) The trail of establishing therapeutic goals and/or limitation to treatment for medical patients admitted to HDU is established. **Remains in progress.**

2m. (Ref. 2012/2/2) The responsibility for a HDU patient’s admission, care and discharge is with the primary team with the intensive care team becoming involved only after a referral with the amount of requirement involvement clarified at the time of referral. Need to address the management of demands on HDU beds when the HDU is full and ensure effective communication of treatment plans and limitations on care of HDU patients to on call teams. **Remains in progress.**
### Obstetrics and Gynaecology

3a. (Ref. 2011/1/7) Have an arrangement with Wellington to have post mortems performed by a qualified pathologist in the field. **Resolved.**

3b. (Ref. 2011/2/6) Continue to seek informed consent from parents and project the positive side of post mortem on a still born baby. Aim to get the post mortem results through as quickly as possible. All Lead Maternity Carers, Paediatric and Obstetric Consultants are aware. **Progressing.**

3c. (Ref. 2011/2/7) Continue to wait for a national policy on testing and advice over issue of consent. **Remains in progress.**

---

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

See b) above for the recommendations/actions described under each individual issue.

---

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

<table>
<thead>
<tr>
<th>Emergency Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Issue has been transferred to the ED Risk Register for ongoing management and monitoring.</td>
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</tbody>
</table>

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- Provide clinical advice to senior management, the Executive Management Team, Chief Executive, and through the Chief Executive to the Taranaki District Health Board.
- Encourage all individual staff members to seek out examples of good clinical practice, to review these and encourage their introduction to the Taranaki DHB as appropriate.
- Receive advice about research projects involving hospital and community based services.
- Provide advice to the Taranaki DHB on clinical governance issues.
- Provide a written summary report of activities, progress and plans on a six monthly basis to the Chief Executive.
- Facilitate the development of a local Taranaki Clinical Ethics Advisory Group.

Taranaki DHB acknowledges that there is a shared responsibility to ensure clinical practitioners are competent to work in their particular clinical setting. Credentialling is a tool for clinical practitioners to demonstrate that they have the knowledge, skill and organisational support to provide safe and effective clinical care to patients. It is part of a wider organisational quality and risk management system designed primarily to protect the patient. While the Credentialling Policy is intended to be an all encompassing policy, the emphasis is on senior medical staff credentialling. Over time, the aim is to develop credentialling programmes for other health professionals working at a senior level, or those with an expanded or extended scope of practice.
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Benefits to health and disability consumers from quality improvement activities outlined in this report include:
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• Seeking out best practice and then standardising treatment pathways and equipment to be utilised.

Please send to: Clinical Leadership, Protection and Regulation
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APPENDIX 1
Quality Assurance Activities protected under the Health Practitioners
(Quality Assurance Activity: Taranaki District Health Board) Notice 2009
as at 12 November 2012

Department: Surgery
Date PQAA Registered: 1 April 2005  Re-registered: 13 November 2009
Protected QAA:
• Morbidity and Mortality meetings (weekly).
• Annual specialty directed audit projects.
• Vascular audit data.
• Risk adjustment POSSUM data.

Department: Corporate
Date PQAA Registered: 7 March 2005  Re-registered: 13 November 2009
Protected QAA:
• Clinical Board meetings: Clinical Board oversees audit and audit processes within Taranaki DHB.
(Note: Specific sections of the meeting of the Clinical Board will be designated as PQAA activity when necessary and the records for that section of the meeting will be handled in accordance with Taranaki DHB policy for PQAA).

Department: Obstetrics & Gynaecology
Date PQAA Registered: 15 February 2005  Re-registered: 13 November 2009
Protected QAA:
• Three monthly Perinatal Meeting.
• Gynaecology Morbidity and Mortality Meeting. (Registered 6 May 2010)

Department: Radiology
Date PQAA Registered: 14 December 2004  Re-registered: 13 November 2009
Protected QAA:
• Case Review Audit: Any known cases of ‘error’ in interpretation of a radiological study/investigation are recorded in a book. Such cases are reviewed quarterly at a formal audit meeting led by the Clinical Director and attended by all radiologists. The Clinical Director summarises the cases reviewed in written form.

Department: Orthopaedics
Date PQAA Registered: 18 June 2008  Re-registered: 13 November 2009
Protected QAA:
• Orthopaedic Department Clinical Audit Meetings and Peer Review Meetings.
• National Joint Registry Data Collection. Conducted routinely in theatre, and the analysis of such data conducted by the Registry.

Department: Ambulance
Date PQAA Registered: 11 January 2006  Re-registered: 13 November 2009
Protected QAA:
• PRIME Committee: The PRIME Committee oversees the response to serious accidents and medical calls in rural areas. Doctors in Inglewood, Stratford, Eltham, Hawera and
Opunake attend incidents with Ambulance. The PRIME Committee is requested to do system audits and case reviews to improve the response.

**Department:** Labcare Pathology (on behalf of Taranaki DHB Diabetes Service Team)

**Date PQAA Registered:** 19 June 2006  
**Re-registered:** 13 November 2009

**Protected QAA:**
- Taranaki DHB Diabetes Service: The Taranaki DHB Diabetes Service Team meets monthly and as part of the meeting the group may discuss case studies and best practice issues. The Overseer will take responsibility for ensuring that the discussion has QAA protection when appropriate.

**Department:** Labcare Pathology

**Date PQAA Registered:** 19 June 2006  
**Re-registered:** 13 November 2010

**Protected QAA:**
- Taranaki Seminars: Laboratory staff meet three times per year at the Taranaki Seminars to attend sessions for their Continuing Professional Development. The intention is to have presentations on specific topics and also include some case studies. The Overseer will take responsibility for ensuring that the discussion has QAA protection when appropriate.

**Department:** Hospital-wide

**Date PQAA Registered:** 13 November 2009

**Protected QAA:**
- Multi-disciplinary Morbidity, Mortality and Improvement meetings. Meetings are held three times a year and involve staff from across the organisation.

**Department:** Taranaki Base Hospital Emergency Department

**Date PQAA Registered:** 5 June 2007  
**Re-registered:** 13 November 2010

**Protected QAA:**
- Bi-Monthly Taranaki Base Hospital ED Morbidity and Mortality Meeting
- Monthly Taranaki Base Hospital Emergency Medical Staff Meetings

**Department:** Hawera Hospital

**Date PQAA Registered:** 31 August 2007  
**Re-registered:** 13 November 2010

**Protected QAA:**
- Hawera Hospital Clinical Services Management meeting, formally the bi-monthly Hawera Hospital Emergency Clinical Review meeting originally registered on 28th January 2005.
Annual Report on Protected Quality Assurance Activities

Organisation Name: Wakefield Hospital

Reporting Period: June 2013 – June 2014

1. Name of Quality Assurance Activity

   Wakefield Hospital PQAA

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

   Incorrect placement of spinal implant.

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

   Open disclosure of incident to patient.
   Root cause analysis (RCA) completed.
   Report of RCA findings to manufacturer.
   ACC treatment injury event notification completed.

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

   Requested improvements to packaging and product.
   Effective communication and education of product changes.
   In servicing for staff on use of new product.
d) Describe how implementation of these recommendations will be monitored:

Report requested from Manufacturer.
Continued use of manufacturer reps to provide education and assistance intra-operatively.

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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:

All clinical incidents, including infection prevention and other clinical audits are reviewed by senior clinical managers and medical staff. These are reported to the Continuous Improvement Committee (CQI) and Wakefield Hospital Clinical Advisory Committee (WCAC). All minutes from the WCAC are referred to Acurity Health Group Ltd Clinical Liaison Committee (CLAC).
All staff and consultants are required to participate in ongoing education and maintenance of professional standards. These are monitored though the credentialing process (consultants) and annual appraisals (staff). The CLAC oversees all clinical audit requirements of consultants and individually addresses any issues as required.
NZ Nursing Council has certified the Wakefield Hospital Professional Development and Recognition Programme (PDRP) until 2016.

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

Wakefield Hospital’s auditing and monitoring systems were externally audited against EQUIP4 standards and Health and Disability Services Standards in March 2014. The hospital received accreditation and certification until 2017.

Continuous review and audit of policies, procedures and consumer feedback ensure processes are focused on patient centered care.

Staff and consultants are aware of their responsibilities though the employment, orientation and credentialing processes.

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Wellington 6145
qaa@moh.govt.nz
Annual Report on Protected Quality Assurance Activities

Organisation Name: Wakefield Hospital
Reporting Period: June 2012 - 2013

1. Name of Quality Assurance Activity
   1. Reportable Clinical Event Analysis
   2. Morbidity and Mortality Meetings

a) List any problems or issues that have been identified in the course of the activity:
   1. No RCE’s were received in the reporting period that identified any problem or issues.
   2. Nil – no issue have been identified in the reporting period.

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

c) List what recommendations have been (or are to be) made as a result of the activity:
   1. Nil
   2. Nil
d) Describe how implementation of these recommendations will be monitored:

1. Nil
2. 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:

1. Nil
2. Nil

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

1. N/A
2. N/A

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Annual Report on Protected Quality Assurance Activities

Organisation Name: Waikato District Health Board

Reporting Period: 6th November 2012 – to 5th November 2013

1. Name of Quality Assurance Activity

Health Practitioners (Quality Assurance Activity: Waikato District Health Board) Notice 2009

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

• Numerous issues identified and all available on request. In summary:
  • Clinical issues relate to a wide range of issues, including: systems failures, inadequate communication between clinical staff, poor documentation in clinical record, recognition of complex patients, specialist delivered out of hours transport service for high acuity patients, wrong site surgery, medication errors, compliance with DHB policies, etc
  • Non-clinical issues relate to a range of issues including physical environment of workplace, transfer issues, inconsistencies in reviews across services, and insufficient resources.

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

• Each PQAA has identified its own actions to address issues and these are all available on request. In summary the most common actions taken include:
  • Updating of current clinical guidelines/ protocols or development of new protocols to incorporate national or international best-practice guidelines
  • Review of individual work practices / standardisation of work processes
  • On going staff education
  • Improved communication with other services / referral processes

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

• Numerous recommendations were made as a result of PQAA activity. These are all available on request.
  • Recommendations generally reflect the need for the actions outlined in b) above to be taken. These recommendations were made to individual services and, where appropriate, implemented at an organisation-wide level, e.g.,
    • Any risks identified have been transferred to the organisation risk register for action
    • VTE policy being developed as a DHB wide policy
    • DHB clinical audit of documentation to commence in January 2014 at the request of the Board of Clinical Governance.
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:

- Competence of the organisation is regularly reviewed by the Board of Clinical Governance and executive management groups of Waikato DHB.
- Competence of the DHB’s agents is reviewed through the contract management process as per the DHB Tenders and Contracts Policy.
- Competence of the DHB’s employees is reviewed through the performance management process as per the DHB’s Performance Development policy.

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

- A wide range of benefits to health and disability consumers has resulted and will continue to result from Waikato DHB’s PQAA activities. These include:
  - Maintenance of high professional standards and ongoing improvement in assessment and management of patients through benchmarking against internationally accepted clinical outcomes.
  - Improved processes and staff education have helped to increase the reliability and safety of clinical care, with the aim of reducing patient harm.
  - Increased staff awareness of latent errors and their potential for harm.
  - Improved focus on patient safety with closer monitoring of clinical practice.
  - Benefits to consumers are that clinical procedures and practice become safer / more effective as recommendations are implemented and learnings are shared across the organisation.

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Health Practitioners (Quality Assurance Activity: Waikato District Health Board) Notice 2009

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

- Numerous issues identified and all available on request. In summary:
  - Clinical issues relate to a wide range of issues, including: systems failures, communication between clinical staff, medication errors, poor documentation in clinical record, lack of data for clinical decision-making, availability of equipment, delayed diagnosis, lack of documented processes and procedures, and insufficient staff resource, recognition of complex patients, compliance with DHB policies, etc
  - Non-clinical issues relate to a range of issues including reviews within specific time frames, serious event resources, review of incident forms, communication between services / staff, consent compliance, poor input from staff records, and insufficient resources.

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

- Each PQAA has identified its own actions to address issues and these are all available on request. In summary the most common actions taken include:
  - Updating of current clinical guidelines/ protocols or development of new protocols to incorporate national or international best-practice guidelines
  - Review of individual work practices / standardisation of work processes
  - On going staff education
  - Improved communication with other services / referral processes

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

- Numerous recommendations were made as a result of PQAA activity. These are all available on request.
- Recommendations generally reflect the need for the actions outlined in b) above to be taken. These recommendations were made to individual services and, where appropriate, implemented at an organisation-wide level.
d) Describe how implementation of these recommendations will be monitored:

- At the service level implementation of these recommendations has been monitored by the relevant service’s Quality meetings or the relevant Clinical Director / Clinical Nurse Leader / Team Leader / Service Quality Coordinator.
- For serious event reviews, the Quality and Risk Service monitors the implementation of all planned actions and reports on progress to the Board of Clinical Governance quarterly. In addition, SAC1 event progress against the national 70wd timeframe is now monitored monthly and reported to BOCG.

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:

- Competence of the organisation is regularly reviewed by the Board and executive management groups of Waikato DHB.
- Competence of the DHB’s agents is reviewed through the contract management process as per the DHB Tenders and Contracts Policy.
- Competence of the DHB’s employees is reviewed through the performance management process as per the DHB’s Performance Development policy.

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

- A wide range of benefits to health and disability consumers has resulted and will continue to result from Waikato DHB’s PQAA activities. These include:
  - Maintenance of high professional standards and ongoing improvement in assessment and management of patients through benchmarking against internationally accepted clinical outcomes.
  - Improved processes and staff education have helped to increase the reliability and safety of clinical care, with the aim of reducing patient harm.
  - Increased staff awareness of latent errors and their potential for harm.
  - Improved focus on patient safety with closer monitoring of clinical practice to potentially reduce incidence and secondary complications.
  - Benefits to consumers are that clinical procedures and practice become safer / more effective as recommendations are implemented and learnings are shared across the organisation.

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