



# Quality Improvement Committee

## Minutes

### Meeting details

Date and time	Friday 30 March 2007, 9.30AM – 4.30PM
Venue	Wellington Airport Conference Centre

### In attendance

Committee members	Pat Snedden (Chair) (PS), Alan Merry (AM), Barbara Crawford (BC), Barry Taylor (BT), Catherine Rae (CR), Cindy Farquhar (CF), Jean Hera (JH), Jim Vause (JV), Judi Strid (JS), Kevin Hague (KH) arrived 10.45am, Mary Seddon (MS), Robin Youngson (RY),
Secretariat	Gillian Bohm (GB), Lote Gatland, Faith Roberts (arrived 12.10pm)
Guests	David Galler (DG), Geraint Martin (GM), Bruce Anderson (BA) (12.20pm – 2.15pm), Nigel Miller (10.00am – 12.00pm), Mary Gordon (10.00am – 12.00pm), Sue Ineson (2.30pm – 3.15pm), Neil Chave (2.30 – 3.15pm), Clare Kirk (2.30 – 3.15pm).
Apologies	Barbara Greer, Kevin Hague (late)

Summary of discussion and decisions	Action points
<p><b>1. Welcome, apologies and Chair's report</b></p> <ul style="list-style-type: none"> <li>- PS welcomed JH, CF and JV, members who were not present at the first meeting.</li> <li>- Apologies received from BG (absent) and KH (late).</li> <li>- PS introduced a new format for future QIC meetings:               <ul style="list-style-type: none"> <li>- Karakia to be at the beginning of every meeting</li> <li>- Five minutes allocated to a Committee member at each meeting to reflect on one aspect of their health life.</li> <li>- Invite a DHB CEO to be present at every QIC meeting, and extend the invitation to stay.</li> </ul> </li> </ul> <p>PS started off proceedings with a brief comment of the Auckland Lab High Court decision.</p>	
<p><b>2. Presentation on Patient Flows – Canterbury DHB</b></p> <p>See presentation.</p> <p>Canterbury DHB hosting a conference on patient flows on 14 and 15 May 2007.</p>	Secretariat to send details of conference to all Committee members.
<p><b>3. The Quality and Safety Agenda</b></p>	
<p><b>3.1 Mortality Review presentation – BT</b></p> <p>See presentation.</p> <p><b>Discussion points to note:</b></p> <ul style="list-style-type: none"> <li>- Confidential reporting is needed so people can be open with a reduced risk of self-incrimination.</li> </ul>	

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<ul style="list-style-type: none"> <li>- BT recommended a change to legislation so people, who would not normally have access to Child and Youth Mortality Review Committee (CYMRC)-collected information, can participate in a review while other non-agents are there. Currently one agent cannot discuss cases with several non-agents at a time.</li> <li>- The current law limits the family perspective of not wanting what happened to them to happen to someone else.</li> <li>- 70% of deaths can be attributed to factors where things could have been done differently.</li> </ul> <p><b>Mortality Review Database</b></p> <ul style="list-style-type: none"> <li>- The Ministry of Health has a contract with Otago University to manage a mortality review database for CYMRC and PMMRC (the Perinatal and Maternal Mortality Review Committee).</li> <li>- Quick data is important to the process of mortality review.</li> <li>- Data is collected from various sources including Births Deaths and Marriages, New Zealand Health Information Service, Coroners.</li> <li>- No information is collected from ACC or the Office of the Health and Disability Commissioner (HDC). The Office of the HDC had not been considered as a source of information. Information from ACC was very small so this avenue was not pursued.</li> <li>- New Zealand Health Information Service (NZHIS) data was not useful as the information was 3 years old.</li> </ul> <p><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>- CYMRC needs QIC's help.</li> <li>- CYMRC needs to have local groups functioning across the country. (Auckland participated in the pilot but was concerned with the legal issues and have not continued since the pilot finished).</li> </ul> <p><b>Adult mortality review</b> General consensus to support the adult mortality review paper.</p>	
<p><b>3.2 Improving Consumer Participation – JS</b> See handout.</p> <p>The Office of the HDC is seeking to support the establishment of a peak national consumer body. A two step approach:</p> <ol style="list-style-type: none"> <li>1 Form a collaborative of organisations that support a consumer focus.</li> <li>2 Ask organisations whether they are in a position to provide some partnership. Contributions so far range from \$1000 to \$10000. Sponsorship achieves consumers to attend the summit from all around the country.</li> </ol> <p>There was successful representation at the first summit.</p> <p><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>- QIC to be supportive of the development of a national consumer entity.</li> <li>- QIC could help fund this.</li> </ul> <p>General approval of the Committee to help fund and support a national</p>	

Summary of discussion and decisions	Action points
consumer entity.	
<p><b>3.3 Open Disclosure &amp; Just Culture – GB</b> See handout.</p> <p><b>Discussion points to note:</b></p> <ul style="list-style-type: none"> <li>- There is a growing body of evidence on the effectiveness of undertaking “open disclosure” when harm has occurred during the process of care.</li> <li>- General consensus that this be the focus of the management of incidents priority for the first year.</li> </ul>	
<p><b>3.4 Improved Management of Medications - BA</b> See presentation.</p> <p>AM declared a conflict of interest as he owns shares and is a member of the Safer Sleep LLC Board, which produces a barcode based safety system for medications in anaesthesia. AM left then meeting during the presentation.</p> <p>BA pointed out that all the information he was to present will be available to the public shortly. General approval by all Committee members that AM rejoin the meeting. AM rejoined the meeting.</p> <p>Discussion ensued as to how to manage conflicts of interest. Reference was made to the guidelines provided by the Ministry of Health to the Committee.</p> <p>MS chaired meeting for 15 minutes during this presentation as PS was absent.</p> <p><b>Points to note from presentation:</b></p> <ul style="list-style-type: none"> <li>- There are several high level assumptions related to adverse event errors.</li> <li>- This project only looks at medication errors and preventable drug events in hospitals.</li> <li>- Most medications under the new system will need to be packaged and barcoded down to the unit dose.</li> </ul> <p><b>Discussion points to note:</b></p> <ul style="list-style-type: none"> <li>- This project is for hospitals only for now</li> <li>- E-medication records are not widely used</li> <li>- E-prescribing is different from an e-medication record - can have one without the other. Bar-coding/bedside verification will not work without having either e-prescribing or e-medication record.</li> <li>- Other alternatives could be a locked draw at the patient’s bedside. Although a cheaper option, there is still room for error as to the amount administered.</li> <li>- Most control is at the DHB level. Once DHBs have the system in their region, it could spread to other areas such as residential care.</li> <li>- Concern was raised that approaches to be initiated in the DHBs will require that CEs are consulted and informed as to how this project is going to help them.</li> <li>- Medicine reconciliation has not been included in this project, it</li> </ul>	<p>Members to forward their conflicts of interest to the secretariat.</p>

Summary of discussion and decisions	Action points
<p>will be an integral part of e-medication record.</p> <ul style="list-style-type: none"> <li>- Bedside verification forms a small component of the process that improves the medicine reconciliation.</li> <li>- This project needs a consumer focus.</li> <li>- There are no safeguards built into this project as yet.</li> <li>- The simplistic approach to this will cause it to fall over when complex issues arise, eg. neonatal prescribing, variable doses - insulin, self-administration.</li> <li>- Bar-coding is one tool in total medication safety process. A system can be provided but culture change is needed. Eg, provide a bar-code to go on syringes but people are scanning them from the sheet instead of putting it on the syringe.</li> <li>- Evidence of successful implementation in overseas organisations so we are not reinventing the wheel.</li> </ul> <p><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>- QIC to be the driving force behind this project, either the Committee itself or a project reference group stemming out from QIC.</li> <li>- Ministry of Health to support this project but it should be run by the sector.</li> </ul>	
<p><b>3.5 Feedback from Safe and Quality Use of Medicines (SQUM) – MS</b> See handout.</p> <p><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>- QIC to support SQUM secretariat to set up a network/website (may not cost a lot).</li> <li>- Financial support for the development, consultation and implementation of a national drug chart.</li> <li>- SQUM developed a warfarin toolkit. Support needed to distribute a DVD and flipchart and other information.</li> <li>- Primary/secondary interface needed to bring people together and come up with a model of medication reconciliation that can be piloted.</li> <li>- Advocacy from QIC for an e-medication record (no finance involved).</li> <li>- Improve resources for consumers to get information quickly.</li> <li>- Training and education programme for staff involved in the medication management process.</li> <li>- SQUM could be a subgroup of QIC.</li> </ul>	
<p><b>4. Health and Disability Commissioner paper – JS</b></p> <p>The HDC has open disclosure as one of the key initiatives in the strategic plan. He has written to all DHB CEs, which started in November last year. What he found was that 6 DHBS have open disclosure policy and the remaining will draft a policy on this.</p>	<p>JS to advise the Committee on the progress on DHB disclosure policies.</p>
<p><b>5. Development of QIC priorities</b></p> <p>DHBNZ memo tabled by PS. The memo was unanimously approved by DHBNZ chairs.</p>	

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<p>AM left the room removing himself from the priority discussion because of the conflict of interest noted in 3.4 above.</p>	
<p><b>5.1 Discussion points to note</b></p> <ul style="list-style-type: none"> <li>- The DHBNZ structure allows us to look at implementation in a regional way.</li> <li>- We can pilot the priorities in different areas, so we can get to a point where this is adopted as mainstream practice.</li> <li>- Could move from regional to national.</li> <li>- The Institute of Healthcare Improvement has excellent information on how to implement a collaborative.</li> <li>- Some concern on QIC having sub-groups reporting to them.</li> <li>- QIC has a governance role; DHBs will be the 'doers'. The 'doers' are likely to be existing networks of people, eg. Quality and Risk Managers, SQUM, Directors of Nursing (DoNs), Chief Medical Officers (CMOs) etc. Keep in mind particular programmes or groups. However, we need to be aware that we will not force organisations to do things that are not a priority for them.</li> <li>- If we roll projects out nationally we could have new groups being established.</li> <li>- We want people to "put their hands up" to do these things.</li> <li>- There are things that we can do to get people to do these things. Eg. Get Don Berwick to come out to speak to CEs and CMOs</li> <li>- We would not want to pilot all the priorities in all 21 DHBs.</li> <li>- There is some work on just culture and open disclosure leading to a national focus.</li> <li>- The capacity of people to feel themselves able to lead this kind of thinking. What we need to do as a precursor to release advice on these priorities.</li> <li>- DHB CEs table are at saturation point. Capacity to take on new work is limited. Need CE minds as opposed to hours.</li> <li>- Agenda is very credible. Common picture in lots of places. Do we need to do all of these priorities? If this is a priority, then we need proper sponsorship by Chairs and CEs.</li> <li>- The requirement of Chairs/CEs is that we are going to make this part of the KPI measures.</li> <li>- The way for QIC to introduce itself into the DHB process. Our thinking takes us down this route, these might be the priorities that some of you will need to pick up. Once receiving their reflection then adopt some priorities. This is not adding another burden, rather it has the potential to rationalise the multiple activities already being undertaken across all DHBs. This might have insight in reducing stress, improving the way things are done.</li> <li>- The six priorities in the report have a very DHB secondary focus. Concern that there are no institutional standards for primary care strategies in place.</li> <li>- Concerns that quality assurance is not included.</li> <li>- Need to think about primary care. Eg. Infection control. You would think GPs would have standards for sterilisation but they do not.</li> <li>- We do not know what is involved in implementing these priorities. The paradigm includes the whole market place. In terms of implementation we need to look at bottom up. We need to be</li> </ul>	

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<p>highly explicit that this is a preliminary look at priorities.</p> <ul style="list-style-type: none"> <li>- We can start with secondary care with the move to primary care.</li> <li>- We are at the first stage of this process. We are still at risk here. We will have a better view with a gap analysis. We need to give ourselves a year to formulate a gap analysis.</li> <li>- There are already activities taking place in all of those areas. It is important to encourage collaboration from those already doing these priorities to save duplication</li> <li>- The Medical Council and the New Zealand Nursing Organisation are already working on the infection prevention and control area. There is currently no co-ordination across these groups.</li> <li>- If the Minister of Health says these priorities are important to all high-level people then DHB CEs will buy into it.</li> <li>- DHBs are very responsive to the priorities indicated by the Minister. The Minister rarely gives explicit direction but does give informal direction.</li> <li>- It is important that the Chairs group says that quality improvement is one of their priorities and for DHB CEs to sponsor it.</li> </ul>	
<p><b>5.2 Review of presentations given</b></p> <p>AM rejoined the meeting.</p> <ul style="list-style-type: none"> <li>- Unanimous support for the paper on consumer participation.</li> <li>- Support for further development of the other presentations: <ul style="list-style-type: none"> <li>- Just culture/open disclosure/pastoral care</li> <li>- Patient flows</li> <li>- Medication management – there is already resource for this.</li> <li>- Mortality review.</li> </ul> </li> </ul> <p>JV declared a conflict of interest as he is an assessor for the Royal New Zealand College of General Practitioners' Cornerstone programme.</p>	
<p><b>5.3 Template for priority areas</b></p> <p>The Committee listed the following themes for further review together with the sponsors:</p> <ul style="list-style-type: none"> <li>- Incident management – BC, CR, RY, JH</li> <li>- Improved management of medication – MS, DG, BT</li> <li>- Patient flows – JS, CF, DG, KH, JV</li> <li>- Infection prevention and control - JS, MS, BC, CR,</li> <li>- Education and Training – GM, BC, CR, JS, JV</li> <li>- Consumer participation - JH, DG, JS, RY</li> <li>- Mortality Review - BT, AM, MS</li> <li>- Chartbook - CF, JV.</li> </ul> <p>The secretariat will prepare a 2–3 page analysis paper per theme (as listed above) to provoke a conversation with the health sector about QIC's 'direction of travel'. It will include the following:</p> <ol style="list-style-type: none"> <li>1. Description of intervention</li> <li>2. Outcomes we wish to measure</li> <li>3. Describe what success looks like in 1 and 3 years.</li> <li>4. What are the risks of doing it/not doing it</li> <li>5. Outline the 'contest of ideas' and where they impact on</li> </ol>	<p>PS to write a one pager about role/position of QIC in overseeing the identified projects and distribute to members.</p> <p>KH to invite PS to speak to CEs group.</p> <p>Secretariat to send</p>

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<p>implementation</p> <ol style="list-style-type: none"> <li>6. Describe the implementation planning phases               <ol style="list-style-type: none"> <li>a. National or pilot in a few DHBs</li> </ol> </li> <li>7. Identify stakeholder/community audience and propose champions</li> <li>8. Quantify the resource required and for what?</li> </ol> <p><b>Discussion points to note:</b></p> <ul style="list-style-type: none"> <li>- Get these papers on May 2007 Board agendas (post discussion with DHB CEs)</li> <li>- Indicatively we support this. If we get DHB CEs and DHB Chairs to support this then we have a way forward.</li> <li>- If the Minister wants money put to quality then people will pick it up.</li> <li>- Recommendation that Canterbury lead the 'patient flows' priority.</li> <li>- Although outcomes will be measured, some will be process measures.</li> </ul>	<p>completed templates to quality and risk manager's group.</p> <p>Secretariat to draft a 3-page analysis by the week of 16 April on each of the priorities and circulate to identified sponsors.</p>
<p><b>6. Quality Health New Zealand presentation</b> Sue Ineson (Chair), Neil Chave (CEO), Clare Kirk (Service Manager)</p> <p>See handout.</p> <p><b>EQUIP4</b></p> <ul style="list-style-type: none"> <li>- A new accreditation system that includes 3 of the 6 priorities ie incidents, medication management and patient flow</li> <li>- There are 8 criteria of which 6 are mandatory</li> <li>- Criteria are outcome focused</li> <li>- Accreditation will cost 70-80k p.a. for a large DHB.</li> </ul> <p><b>Recommendation</b></p> <ul style="list-style-type: none"> <li>- Support for the idea that more accreditation systems, beyond a 'tick box', is important.</li> </ul>	
<p><b>7. Identification of Allies</b></p> <ul style="list-style-type: none"> <li>- Quality and Risk Managers</li> <li>- Chief Medical Officers</li> <li>- Directors of Nursing</li> <li>- Unions</li> <li>- District Health Boards New Zealand</li> <li>- Safe and Quality Use of Medicines Group</li> <li>- Certain Intelligent Media</li> <li>- Treasury</li> <li>- ACC</li> <li>- National Division of Infection Control Nurses</li> <li>- New Zealand Guidelines Group</li> <li>- Council of Medical Colleges</li> <li>- Health and Disability Commissioner</li> <li>- Health Registration Bodies eg. Medical Council, Nursing Council</li> <li>- Pharmac</li> <li>- SSC develops framework</li> <li>- Consumer bodies</li> <li>- Nursing Bodies</li> <li>- Australian Safety and Quality Commission</li> <li>- Academics and researchers in universities</li> </ul>	

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<p><b>8. Terms of Reference</b> All members agreed to the Committee's revised Terms of reference.</p>	<p>Secretariat to finalise the Committee's Terms of Reference with the Minister.</p>
<p><b>9. Quality Forum and DHB CEO engagement</b> Plan to hold this on 10 October 2007 in conjunction with the Health Innovation Awards. This will include a launch for highlighting champions in the sector.</p>	
<p><b>10. General Business</b></p>	
<p><b>10.1 Epidemiological representation</b> General consensus for clinical epidemiology representation on the Committee. All names to be put forward to PS who will follow through.</p>	<p>DG to give PS clinical epidemiologists for consideration.</p>
<p><b>10.2 Policy for representation at conferences</b> First draft completed by secretariat.</p>	<p>Secretariat to distribute first draft to members for their feedback.</p>
<p><b>10.3 Confirmation of 14 February minutes</b> Minutes amended to include AM's stated conflict of interest. <i>Moved: That the minutes are a true and fair record with amendment.</i> <i>Proposed: RY Seconded: CR Carried.</i></p>	<p>Secretariat to amend minutes.</p>
<p><b>10.4 Correspondence</b> A number of items of correspondence were received by the secretariat. Members to contact secretariat if they are interested in the details.</p>	<p>Secretariat to post correspondence log on quickplace.</p>
<p><b>10.5 Management of Committee papers</b></p> <ul style="list-style-type: none"> <li>- All papers to be distributed to Committee members seven working days before each meeting by the secretariat.</li> <li>- Where relevant, documents are to be clearly marked as confidential/embargoed when distributed.</li> <li>- General rule: Papers given to Committee members are confidential until the Committee determines otherwise.</li> </ul> <p>Committee agreed to make the 'Scoping Priorities Report' publicly available with an introduction outlining that the original purpose of the report was for the Minister of Health only and that it did not go through the usual peer review and editing process due to the limited timeframe.</p>	<p>Secretariat to post the 'Priorities Report' on QIC's website.</p>
<p><b>10.6 Improving Medication Safety Conference</b> SQUM and Pharmac are hosting the conference on 17 and 18 May in Wellington.</p>	<p>Secretariat to distribute details.</p>

Next meeting
<p>Friday, 1 June 2007, 9.30AM – 4.30PM Unisys House, 650 Great South Road, Penrose, Auckland</p>