



Quality Improvement Committee

Minutes and Action Points

Meeting details

Date and time	17 October 2008, 9.30AM – 5.00PM
Venue	Copthorne Hotel, 100 Oriental Parade, Oriental Bay, Wellington

In attendance

Committee members	Pat Snedden (PS), Jean Hera (JH), Mary Seddon (MS), Judi Strid (JS), Nick Baker (NB), Barbara Crawford (BC),
Secretariat	Kathryn Baker (KB), Gillian Bohm (GB), Margie Apa (MA) 2:30pm, Alan Spinks (AS) 11:06am, Joe McDonald (JM1) 11:06am
Guests	Maureen Robinson (MR) 2:12pm, David Galler (DG), Cheyne Chalmers (CC1), Anne McLean (AM1), Peter Jansen (PJ) 12:27pm, Janice Mueller (JM), Chai Chuah (CC) 3:03pm, Karen Orsborn (KO) 10:54am
Apologies	Jim Vause (JV), Alan Merry (AM), Barbara Greer (BG), Cynthia Farquhar (CF), Catherine Rae (CR), Geraint Martin (GM)

Summary of discussion and decisions	Action points
<p>1. Meeting Opening and Karakia Meeting opens at 9:36am. Guests arriving throughout the day are Margie Apa, Chai Chua, Karen Orsborn.</p>	
<p>2. Apologies Jim Vause, Alan Merry, Barbara Greer, Cynthia Farquhar, Catherine Rae, Geraint Martin. Due to absences we do not have a quorum for this meeting.</p>	
<p>3. Health- life Reflection - CC1 Yesterday was the blessing ceremony of the atrium of the new facilities at Wellington Hospital. CC1 was reminded about why being a health professional is important. It was a time of reflecting on honouring the past and what has gone on before us. CC1 spent time remembering health professionals and how the different roles have changed.</p> <p>It is a concern that the old traditional practices will be taken into the new facility. How do we shift common perceptions in order to take new practices into the new facility? This is a big paradigm shift and time will need to be spent working with the health professionals and consumers to make the transition.</p> <p>CC1 was reminded yesterday of the importance of the servant leadership model – the senior hospital management needs to serve the nurses and hospital workers in order to get them to take hold of the vision. The transition is fast approaching and we are bombarded with communication regarding this. We need to remember to honour and treasure the past, but also to build the future and make sure we leave a legacy for the next generation.</p> <p><u>Chair asks for any comments:</u> PS thanks CC1 for his health-life reflection.</p>	

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<p>4. Minutes Sept 8 Meeting Pg 6: the point is not to make the DHB's lives easier – it should be a bi-product Pg 7: whether not 'weather' Pg 8 action point: MS has not yet drafted a letter to the DDG</p> <p>JH moves to pass the minutes, NB seconds, motion carried.</p>	<p>Secretariat to revise minutes for signing at next meeting and post minutes on website.</p>
<p>5. Matters arising not covered in the Agenda – PS JS – wants an update on SCV business case.</p>	
<p>6. Chair's Report – PS <i>Collaboration with Private Healthcare</i> On speaking at a conference in Wellington I challenged the private surgical hospitals (Southern Cross), what is the right thing for New Zealand incorporated? Why shouldn't we be in collaboration regarding quality standards? They were receptive to the idea to have a collaborative approach and would like to be included in future conversation.</p> <p><i>Discussion around Open Disclosure</i> A meeting with Bev Wakem, Ron Paterson, Alan Merry took place to discuss the climate for open disclosure and informing the public, and protection for health workers – attack on blame culture. What is the best way we can improve the confidence of the public in the healthcare system? They were in favour of a major conversation in a public arena to break through the perception that there are different levels of understanding around the protection for people in the sector. Each person was supportive of the work QIC facilitating this discussion.</p> <p><i>NQIP Governance Issue</i> We cannot allow having small groups playing off each other. There is currently a fight regarding issues surround Strengthening the Consumer Voice and the Management of Healthcare Incidents programmes. There is no value in having a fight – we need to have a constructive conversation. We need to improve, collaborate and increase the support and inspire people rather than tear their efforts down.</p> <p><u>Chair asks for any comments:</u> <i>Discussion around Open Disclosure</i> The CEO of the Beth-Israel hospital writes a blog that is available for anyone to see – they posted an entire case of the sentinel event along with what they were doing to remedy it. How can we do the same? It was agreed that something similar needs to happen, but we are a little way from getting a consensus as to how we do this. We need to move towards transparent learning. In a sentinel event the patient and their family are usually most upset about the actions taken after the event rather than the event itself. If they see the issue being addressed it gives them confidence that people will benefit from the correction in the future. These mindsets that push back on open disclosure will not change overnight. By continuing to talk to the media and sector about it repeatedly they will become open to the idea. We need to give the health sector the knowledge, tools and techniques. The concept of open disclosure needs to be encouraged right from the learning</p>	

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<p>phase. The root cause analysis reports are completely transparent and the surgeons are completely protected. We should not expose the clinicians to having the reputation damaged.</p> <p><i>NQIP Governance Issue</i> When establishing a new programme the lead DHB sets it up as a project. However it's much better if they graft it onto an existing structure which can turn it into a business-as-usual practice rather than a project. Some of our initiatives have not been grafted, but just produced on their own and they may have been stronger had they been grafted. In regards to the medication chart – I'm more concerned about the process around decision making. QIC needs to say to the programme steering group that if they make a decision that deviates from the original business case they need to consult QIC. It's all about following the correct processes. This particular decision was made by the working group prior to the steering group – the steering group was not aware of the change before it occurred. This should not be happening. Is there a core expertise in each working group? Do we have confidence in their competence? The NQIP report should show this. People only see this as a progress report. The NQIP report and CFA variations do not get to the sort of detail that is required to pick up these issues.</p>	
<p>7. Report on Patients Awaiting Cardiac Surgery - KO Currently each DHB rates, and assigns resources in different ways for patients on waiting lists. The five-year plan is to increase the level of service delivery by 35%.</p> <p>The two cardiac reports are a good background to this issue. The Ministry of Health would like QIC's opinion about the incident reporting processes and mortality review processes. How can senior DHB management and MOH be alerted to major issues faster?</p> <p><u>Chair asks for any comments:</u> When someone on the cardiac waiting list dies how do we stop that person from being recalled at a later date? There is no single point of contact at the DHB that removes a person from the waiting list. We need to link this up with the mortality review database. It is an easy fix for the Child and Youth database system. A study looks at deaths on the cardiac waiting list. A programme was designed at the time so the data could be fed in nationwide but this was denied by MOH four years ago. We also need to identify when someone dies from another cause when they're on the cardiac waiting list. Currently, the nurses are checking the obituaries to see who should be removed from the waiting list as the reporting takes far too long. It is currently two months but was two years at one stage. KO has witnessed this at other hospitals in New Zealand as well – not just Wellington Hospital. The National Incident Management system should be broad enough to cover these preventable deaths as well. It doesn't make sense to have a separate system. We also need to consider the deterioration of patients while on the waiting list. A patient's condition / status' will change – how do we reassess someone's status and boost them on the priority list accordingly? There is currently a lack of clarity around roles regarding checking patients. We need triangulation of incident data, mortality data, and coroner's data. This</p>	

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<p>should be within our scope.</p> <p>Regarding the communication of the gravity of the situation to senior management, there were multiple quotes in the CCDHB report that state how dire the it is. We may need a better system for communication. The CPAC score is supposed to be transparent and fair but we do not even know if it is reproducible to other places. It needs evaluation on its reliability.</p> <p>If we're looking at a system we need to think about primary care providers and how they will fit.</p> <p>In the current system, there is no one responsible to fill in the correct forms when someone dies on the waiting list. GP's are struggling to communicate back to DHBs regarding patient deaths. When the National Incident Management system is up and running we need to include the primary care sector.</p> <p>Is this the kind of issue that would be parallel to someone's diagnosis in waiting for cancer treatment?</p> <p>Elective surgery has had a disproportionate amount of attention because its so easy to measure.</p> <p>It will be more difficult to sort out the responses to the issues that arise from the data.</p> <p>How transparent is the assessment to the patient? The patient should know their level of seriousness when they are assessed.</p> <p>It depends on the doctor / hospital, some do and some don't communicate how serious their condition is to the patient.</p> <p>The goal of six months does not really help as some people will not last one month.</p> <p>If GPs were given an opportunity to notify a central group about an adverse event that would be one pathway for central collection. Or we could have a complete mortality review system. C&Y have 70% of that system in place.</p> <p>Why do we have such variation? How do we act now to improve the chances of life and not just collect data better? Can there be an informed consensus of a suitable waiting time?</p> <p>There will always be deaths on the waiting list. New Zealanders are waiting much longer for cardiac treatment than patients overseas.</p> <p>We don't have a system to get the assessment information and changes in status to the correct people in a prompt fashion.</p> <p>Cardiac surgery is only to improve quality of life, not longevity. CPAC is supposed to be prioritized on 'need' and 'benefit'. Not all patients can be reviewed for preventability – that would be an enormous amount of work.</p> <p>The clinicians were aware at the time that something was going on, but they didn't have all the info. CCDHB does not have the correct clinical governance and risk management systems to identify issues. These are things that have now been rectified.</p> <p>Are we able to have an alert to notify hospitals that a patient is on a waiting list?</p> <p>There are two issues to respond to:</p> <ol style="list-style-type: none"> 1. How to ensure deaths on the cardiac waiting list are reported swiftly. This will coincide with the role and function of the mortality review system. 2. Pre-death scoring system – is this adequately understood? <p>QIC will come back to KO on a way to deal with this.</p>	
<p>8. Next steps in working with Primary Care - PS</p> <p>QIC received a lot of info and enthusiasm out of last meeting's Primary Care workshop. The workshop for the October meeting was cancelled due to lack of availability of participants. We need to work out a plan as to how we act on this information. Is anyone keen to get involved? We need the leadership within</p>	<p>PS, DG, BC, JM to meet with key primary care people before Christmas.</p>

Summary of discussion and decisions	Action points
<p>If we want this to happen we can do it voluntarily but the IHI also facilitated it with demonstrations about collecting and managing data. Agrees with showing the benefit to real people through patient harm stories.</p> <p>We want everyone to be involved in this – primary and secondary care. The approach needs to be analysed well regarding techniques of delivery. It’s about the entire healthcare system.</p> <p>The business case makes it look too much like a programme rather than a strategy. We don’t want to brand it wrongly.</p> <p>The idea of regional facilitation will be terrific rather than having the strategy’s success hinged on one person’s enthusiasm at a lead DHB.</p> <p>To what extent are New Zealand healthcare workers going to say “we’re just copying America”? Are we able to encapsulate it into something bigger and do something new?</p> <p>This is not a strategy, this is an action plan for a strategy. We don’t have anyone regionally positioned to support the processes.</p> <p>Agrees that this is an action plan for a strategy. There is no statistical process knowledge in service improvement roles. Maybe we need to approach the people at DHBs who are responsible for improving services.</p> <p>At ADHB we started using run charts this year. Optimising the Patient Journey has taught all the required methodologies.</p> <p>The service transformation people will not be the ones performing the change. You’ll need to get the clinical hearts and minds.</p> <p>Should we acknowledge how many lives are being saved currently? And then provide tools to take it further? Saving <u>another</u> 1000 lives.</p> <p>This is highly centered around a tools based approach. This is about refining current practice.</p> <p>The IHI celebrated their success stories rather than their current failure stories.</p> <p>What is this programme going to offer roles like physiotherapists? We have to be able to link it to what’s there for different roles to contribute.</p> <p>We’re proposing to strengthen the whole framework rather than plant a new tree.</p> <p>We need to form a solid strategy on how to sell this to the clinicians etc.</p> <p>We need to communicate QIC’s buy-in to this programme to senior level management of DHBs.</p> <p>It’s all in the way we present it so it shows workers it will make things easier.</p> <p>IHI won hearts and minds by offering a voluntary collaborative.</p> <p>This can be linked into our priority for education and training.</p> <p>We need to actually make this happen. We need firepower from the MOH to get this moving. CEOs need to communicate that the campaign is coming up and is voluntary.</p> <p>Is there a way to embed it so a change in minister will not shift the support off the campaign?</p> <p>10. QIC becoming independent entity QIC would like input on the way this independent entity is created.</p> <p>11. Review the CYMRC report – NB How do we use this committee productively in the health sector? Should this be an advocacy of praxis?</p> <p><u>Chair asks for any comments:</u> The report’s recommendations should be split up and send relevant ones to the minister, relevant ones to parents etc. Ethnic trends need to be included in the report. There is a reporting system at ACC that may assist in the reporting of deaths in</p>	<p>PS to contact the Minister for his support.</p> <p>PJ to send NB more info</p>

Summary of discussion and decisions	Action points
<p>order to turn the health system off for certain patients and avoid re-traumatising families.</p> <p>Do you look at gender?</p> <p>We need a warning on the charts where Maori and Pakeha statistics see-saw. Including 'do's' and 'don'ts' would be invaluable. The current report does not show how the statistics change when considering wealth and ethnicity.</p> <p>12. Reports from Chairs of PMMRC and CYMRC - NB</p> <p><u>Chair asks for any comments:</u></p> <p>When MSD does a review do they communicate the findings to CYMRC? NB – there are sensitivities about information sharing that we are trying to work through. Where does justice fit in getting information through CYFS. NB – the coroner will inform us of the death of a child in the prison system. However if the info relates to a current court case we may not receive that info until after the case is completed.</p> <p>The committee supports this report. NB to bring a draft of the next report to the next QIC meeting in 2009 for QIC to feedback on.</p> <p>QIC receives the report and adopts the recommendations. PS moves to adopt the report, BC seconds, motion passed.</p>	<p>regarding the system.</p> <p>NB to bring a draft of the fifth report to the next QIC meeting on 20 Feb 2009.</p>
<p>13. The Prevention of Venous Thromboembolism in Hospitalised Patients – MS & DG</p> <p>There was an HDC report of a patient in Tauranga that died of this condition as they did not know the symptoms. This sparked a nationwide approach to remedy this and a steering group was established. It is a serious condition that is quite preventable and there is an international agreement on how to treat it. This discussion is about galvanising awareness in order to formulate action. QIC needs to express thought for the work the national steering group are currently doing and adopt the current tactic. A national policy and tools have been developed. The policy is currently in draft form and is sent out to the mailing list – see MS to be added to the mailing list.</p> <p>Last meeting JS circulated the Neil Graham presentation and asked that it be added to the agenda. Should this be referred to QIC?</p> <p><u>Chair asks for any comments:</u></p> <p>It is currently unclear how QIC can add value to this programme but the committee is willing to contribute in a way the steering group sees fit.</p>	<p>MS to ask the VTE steering group what they expect from QIC and report back at the next meeting.</p>
<p>14. NQIP Steering Group report – MA & CC</p> <p>The quarterly and monthly reports we're supposed to gain an understanding of the progress on each NQIP. Where there have been some DHBs not performing to their potential the steering group has approached them and offered assistance.</p> <p>Regarding Optimising the Patient Journey, we need clarity as to how Whai Manaaki fits in. It is an enabler that goes before the Optimising the Patient Journey programme.</p> <p>Regarding Infection prevention & Control's hand hygiene, an RFP process to secure a supplier for an alcohol hand rub is underway.</p>	

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<p>Regarding Safe Medication Management, there are eight projects that we have condensed into four clusters. We need to maintain strong linkages between clusters. There is some confusion around common medicine terminology so we have created how all the terminology fits together and presented it to the steering committee. This is a crucial aspect to establish to form a system for coding.</p> <p>Regarding the Strengthening Consumer Voice business case, the MOH is providing advice to the Minister on the kind of legal entity it would be etc. We are also waiting to find out where the funding will come from within the Ministry.</p> <p><u>Chair asks for any comments:</u> SQUM spent three years coming up with a national drug chart. This is a major departure from what was proposed. Can you get a conversation started between your working group and SQUM? What sort of consultation happened in the formation of these standards? CC – it is a draft standard for people to trial. This issue requires a face to face conversation between SQUM and the Safe Medication Management working group. Are there any attempts to do standards for children? CC – we will need to develop a set of standards specific for children. There has been some confusion in Optimising Patient Journey around the project and the wider Whai Manaaki strategy. QIC does not feel well linked to the steering group and feel there is no consultation in the decision making process. There needs to be a standardized process as to how consumer reps are dealt with. There needs to be processes that apply to every programme standardized and stream lined. Regarding consumer participation, we need to select consumer’s based on relevant experience to what the programme is trying to change. The feedback is quite helpful and this will be brought to the NQIP steering group and we will discuss consumer dissipation across all the programmes. We want the NQIP process to be inclusive and collaborative. At the moment the process of decision-making is not well known. We want a report on progress, out-of-scope decisions and upcoming issues. We need to design a system to handle and approve deviations from the original business case.</p>	<p>PS to speak with the Minister regarding this and report back to the committee.</p> <p>CC to organise a face to face conversation between SQUM and the SMM working group.</p> <p>A small group from QIC to meet with MA and look at the documentation and where the progress lies.</p>
<p>15. Management of Healthcare Incidents Programme update – MR The final draft of the policy was presented to the NQIP steering group. Feedback was received and the policy was revised three times. The latest revision had eight recommendations:</p> <ul style="list-style-type: none"> • Moh will identify the process that makes the reporting mandatory • Hold a second round on consultation in 6-9 months to gain knowledge on requirements for support from DHBs to implement • Endorse the idea that the policy remain a working draft for 9 months – the policy is written for implementation in every health care area. But the initial implementation will take place with DHBs. • To provide info on time frames and processes on this policy as a working draft. • To endorse the idea of there being no penalty for lack of implementation while the policy is still in draft. <p><u>Chair asks for comments:</u> There has been a significant development of a draft policy with significant</p>	

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<p>consultation. This is a baseline of running the programme and would like to see QIC's adoptions.</p> <p>Will there be penalties once the policy is final? MR – that is up to the MOH.</p> <p>There is a current incentive framework which is sufficient.</p> <p>The national steering group's recommendation is to accept the draft policy as a best practice document. It should be used by other agencies such as the Coroner's Office and HDC. There is still some work to be done around legal protection. Start off with a provider arm.</p> <p>When are you aiming to have finished training with all DHBs? MR – July 2009.</p> <p>There was some discussion on this week's steering group regarding the lack of a national repository. An interim solution is to have a standardised template for DHBs to use and publish findings on the QIC website. That is a good solution that we will take to the steering group for their consideration.</p> <p>Before we move into reporting events we need to get consistency and common language on how people report events and what events they choose to report.</p> <p>There is also a potential for shared learning.</p> <p>We never included the final step in our scope – who uses this data and how will they share it?</p>	
<p>16. Embargoed HDC Reports - JS</p> <p>The key issue is system failures in referrals. In one case the referral was lost twice from one DHB to another. There is no system for acknowledgement of receipt of a referral. We need the ability to track patients when you refer.</p> <p><u>Chair asks for any comments:</u></p> <p>Does the HDC ever want advice from QIC regarding their findings? Do they want this coordinated in the public arena at the time these documents are released? JS – at this stage it's more about giving QIC a heads up that we may be approached for our comment at a media event.</p> <p>The HDC is another avenue for identifying areas of improvement.</p> <p>This links firmly to OPJ</p> <p>The common view is that QIC should be informed in due time, where there is a public interest to be commented on we should provide that comment. We should support and articulate the changes in place as a result of these problems. We need to pay some attention to patient journey in relation to these issues.</p> <p>QIC receives these reports and refer the aspects that relate to OPJ to the programme for change by DHBs and include recommendation 5.</p> <p>PS moves to accept, MS seconds, motion passed.</p>	<p>QIC receives these reports and refer the aspects that relate to OPJ to the programme for change by DHBs and include recommendation 5.</p>
<p>17. Planning for release of serious and sentinel events - PS</p> <p>Reporting on July 07 – June 08. This will be plugged at the CEO Forum. The DHBs should be relatively prepared for it this time round. We will provide the oversight and governance of the release.</p> <p><u>Chair asks for any comments:</u></p> <p>We started using the SAC codes in Jan 08 will we need to re-do those? Yes, you will need to review them under the old system. The 2010 release will be under the new SAC codes.</p> <p>Post-Christmas we will work on the communications strategy as we receive the reports.</p> <p>Impressed by how the media took to the last release. None of the media tried to stir up controversy.</p>	

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<p>We need to acknowledge consumer involvement. Were there any adverse comments about identifiable data being released? No, only some people who thought their case was not included at all. Do people need warning that their case is being published? DHBs are already notifying people. The introduction of the National Incident Management system will hopefully increase the amount of events reported. This will result in shared learnings.</p> <p>QIC gives PS the authority to release this report.</p>	
<p>16. General Business / Correspondence The QIC annual report is at the printers and will be tabled on Nov 11th. We had committed to having another combined meeting in Nov, is this still going ahead? Do it in Feb 2009 after the release of Serious & Sentinel events. At a future meeting it would be good to get Shelly Hanifern to give an overall perspective on Mortality Review.</p>	<p>Kathryn to invite Shelley Hanifan to QIC's meeting on 20 Feb 2009.</p>
<p>Closure of Meeting PS: Closes meeting at 4:35pm</p>	

Next meeting
20 February 2009 in Wellington

Signed _____ Date _____
Pat Snedden (Chair)