MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 22 July 2014 commencing at 8.45 am in the Boardroom, MidCentral District Health Board

PRESENT

Barbara Robson (Chair)
Lindsay Burnell
Karen Naylor
Richard Orzecki
Phil Sunderland
Duncan Scott
Stephen Paewai

In attendance
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Murray Georgel, CEO
Mike Grant, General Manager, Planning & Support
Carolyn Donaldson, Committee Secretary

Diane Anderson, Board Member (part meeting)
Lyn Horgan, Operations Director, Hospital Services
Michele Coghlan, Director of Nursing
Anne Amoore, Manager, Human Resources and Organisational Development
Susan Murphy, Manager, Quality & Clinical Risk
Rodney Mackenzie, Manager, Business Support
Digby Ngan Kee, Regional Clinical Director, Women's Health (part meeting)
Lorraine Rees, Manager, Infection Control & Prevention (part meeting)
Stephanie Turner, Director, Maori Health and Disability
Communications (1)
Media (1)

1. APOLOGIES

Apologies were received from Cynric Temple-Camp and Kate Joblin. An apology for lateness was received from Karen Naylor.

2. LATE ITEMS

There were no late items.

3. CONFLICT AND/OR REGISTER OF INTERESTS

3.1 Amendments to the register of interests

Richard Orzecki advised he was on the local governance group of the Horowhenua Children's Action Plan.

3.2 Declaration of conflicts in relation to today's business

The following conflicts of interest were noted:

Stephan Paewai declared a potential conflict in relation to item 7.1, Quality Update and 7.2 Workforce Update due to his involvement as a director on the Central PHO.

Barbara Robson declared a potential conflict with any discussion regarding the Maternity Clinical Information System in item 7.4, Regional Women's Health Service update, due to her involvement as a consumer representative on the Maternity Information Systems Programme Steering Group.

6-11

On arrival Karen Naylor declared a conflict in relation to item 7.2, Workforce update and 7.4, Regional Women's Health Service update, due to her involvement with the Care Capacity Demand Programme.

As these papers did not require any decisions, there was no reason why the members should not participate in any discussion.

4. MINUTES

It was recommended

that the minutes of the meeting held on 10 June 2014 be confirmed as a true and correct record.

4.1 Recommendations to Board

It was noted that the Board approved all recommendations contained in the minutes.

5. MATTERS ARISING FROM THE MINUTES

It was confirmed there would be a post event audit undertaken for the Hospital Operations Centre.

Karen Naylor joined the meeting.

It was confirmed that Dr Anna Ranta was Clinical Director, Medicine, Cancer & Community Capital & Coast DHB (0.5), MidCentral DHB (.2) and was the regional clinical lead for Stroke Services.

6. WORK PROGRAMME

The forthcoming workshops for the Master Health Service Plan initiative on 30 July, and a health strategy/ charter workshop following the next board meeting were noted. Committee members were welcome to attend these workshops.

It was recommended

that the updated work programme for 2013/14 be noted.

7. STRATEGIC PLANNING

7.1 Quality update

Riskman

It was noted there was no further work to be done in terms of the three modules implemented. Implementation of the fourth module, quality improvement, had commenced.

Access to Clinisafe

Management undertook to report back more precisely on who now had access to this community pharmacy dispensing database.

Hand Hygiene

The challenge in achieving the hand hygiene target related to staff having a better understanding of the audit. Some education sessions would be held so staff were able to capture the right moments at the right time. Staff were doing well with hand hygiene – the issue was around auditing it.

Diane Anderson joined the meeting.

Integrated Care

Enabling teamwork under the integrated care framework has been assisted by the Map of Medicine Pathways, which has enabled very effective relationships and networks to develop between primary and secondary care. This was evident in the seamless way the Child Health model of care was working.

Clinical Records

Members were advised there was now no intention to retrospectively scan old patient records. When the business case for the new Clinical Records building was developed it included storing older records in the basement. At that stage a decision on whether or not to scan records was delayed to see how things would work out. It has now been decided that there is no need to retrospectively scan the older records as almost 90% of the files being used were only 1-3 years old. Further, as the clinical portal was implemented, records would become electronic.

Medication Errors

A member expressed concern at the number of medication errors, as he felt they were still very high. Management explained that the vast majority of the errors were minor. An example provided was that a slippage in the time of an hour or more when medications were given to patients, would be deemed as a medication error.

Skin Integrity

It was confirmed that the skin integrity improvement plan currently being developed, would be made available to nursing staff outside the hospital. The Director of Nursing commented on the inclusion in MCH's incident reporting pressure injuries that occurred prior to a patient's admission to hospital. Whilst this appears unfair, it was done to ensure early identification and action, as the maintenance of skin integrity was a key core nursing business activity. The two Tissue Viability Nurses took a lead in maintaining it both inside hospital and in aged residential care facilities across the district.

New Patient Satisfaction Survey

Concern was expressed that while the Health Quality & Safety Commission had indicated this survey would be undertaken by email, this could be a barrier particularly for older people. Management agreed, noting that MDHB could not capture email addresses into the current patient administration system (HOMER) so some postal surveying would need to be done until changes could be made to HOMER. When WebPAS was implemented, it would be possible to collect this information electronically.

Use of Cefazolin as the Prophylactic Antibiotic

Management confirmed that there were now only two surgeons continuing to use their preferred antibiotic instead of cefazolin.

Digby Ngan Kee joined the meeting.

Central Line Acquired Bactaraemia (CLAB)

Management agreed to provide some comment on these results at the next meeting.

Smoking Cessation/Mental Health

The difficulties of achieving smoke-free status for the inpatient mental health service were discussed. Management outlined the pathway taken over a number of years, initially including ensuring that the inpatient smoking cessation target was met in Ward 21, which included asking the appropriate questions about smoking and offering advice. Phase two went to ensuring there was support for clients of the MH Service in place in the community in relation to smoking cessation. The focus now was on ensuring there was support for people who were admitted to the unit who wished to give up smoking, and planning for a suitable timeframe for the unit achieve smoke-free status.

The discussion also covered the recognition that MDHB was a smoke-free site and that if people did want to smoke, the expectation was that they did not smoke on the Board's sites. If people were identified smoking onsite, including smoking in their cars, they would be asked to stop or leave the Board's site. It was becoming better known that if a site was smoke-free, that meant all aspects of the site were smoke-free.

6/13

Falls Prevention

The Committee felt the good work done this year should be acknowledged and staff thanked for their work.

Chaplains/Spiritual Support

A powhiri was held recently to welcome the first two graduates from a Manaaki Hauora initiative aimed to encourage Maori Chaplains into the DHB/health sector. The chaplains were doing their training in Christchurch, and each would spend one day per week for six months at MDHB.

Family Violence Intervention Programme

The issue of how to coordinate similar initiatives run by various groups throughout the country was raised. Management advised this was achieved through good communications with the groups. The Family Violence Intervention Programme was a national programme, supported by the Ministry and implemented within a consistent framework.

Influenza Vaccination Programme

There had not been an increase in the number of people coming into MCH hospitals with influenza recently, as had occurred in Auckland/Waitemata.

O'Shea No Lift Programme

The need to address compliance in achieving the critical elements of the No Lift programme was raised. Management noted that all programmes need periodic attention to support staff, and that it was human nature for routines to slip from time to time. Ongoing staff education together with such things as registration requirements should ensure compliance across the various competencies required by different professional groups.

It was recommended

that this report be received

7.2 Workforce update

Maori Workforce Information

The information in the report on Maori workforce data was appreciated. The potential for Maori workforce development and engaging with Maori managers nationally was raised. Management acknowledged the report did not contain all information on the Maori workforce but it could be covered in the next report if desired particularly as Stephanie Turner, Director of Maori Health & Disability, would be available to assist.

Management advised there was a lot of work going on in terms of the Maori workforce and encouraging Maori to enter the health sector. Some were outlined, eg Kia Ora Hauroa have provided a scholarship to support a local student to develop a webpage for MDHB. The intention is to encourage other young people to think about a career with MDHB; how to get information through national strategies; DVDs; and examples of role models.

Management agreed to provide information on the overall workforce employment statistics with regard to employment status in the next report.

Management was congratulated for the comprehensive report.

Primary Health Workforce Data

Management advised this data did not belong to MCH and therefore was not included in this report. Also it would be difficult to obtain, given the number of providers. The information would be more appropriate to a board report, and reporting it might be a possibility.

Bipartite Action Group (BAG)

This group has been in place for a number of years, and involves collaboration between MDHB's leadership/management and with most of the health sector unions. All other DHBs had a similar forum.

Tu Kaha Initiative

This is a biennial conference developed by Maori across the central region. It was hoped to have more non-Maori staff attend this time, so there could be a sharing of information on Maori models of innovation and thereby gain support and understanding in the wider sector.

New Zealand's Medical Workforce

The inability of DHBs to place all medical graduates in first year house officer jobs (PGY1) at the end of 2013 was raised and discussed. This was a result of the national strategies put in place to increase the medical workforce by increasing the number of medical graduates by 20 per year for several years in each of the two universities. Steps were now being taken to ensure graduates were exposed to all specialties and in particular General Practice. The Medical Council were asking PGY1 and PGY2 students to do three months training in this area.

Management emphasized it was a good situation to be in, as there were now sufficient graduates to meet the medical workforce demand.

Nursing Workforce

Management advised 70 applications were received for the nursing entry to practice programme (NETP) for the second half of the calendar year, but MCH was able to offer only five formally funded positions and four additional non-funded positions. Nationally there were several hundred nursing graduates looking for work. It was the intention for all nursing graduates to receive employment within 12 months of graduation, and the central region DHBs have been given a target of increasing the number of nurses employed to the NETP by 2%.

Annual Leave

Management confirmed the liability for annual leave was accrued. The annual leave level was high. Management had developed a plan to support staff with high annual leave levels to take their leave. Concern was expressed that there could be barriers to people taking leave, and that management needed to be sure staff were able to take their leave.

Exit Interviews

Management advised feedback on the main reasons why people said they would not return to work at MDHB were, for example, because they were leaving the district or retiring; it was not necessarily because they did not want to work for MDHB.

It was recommended

that this report be received.

7.3 Clinical Board Annual Report 2013/14

Management advised the difference between the Clinical Board and the Clinical Leadership Council was that the Clinical Board's role related to MCH activities and the Clinical Leadership Council's activities covered the whole MDHB district.

It was recommended

that this report be received.

7.4 Regional Women's Health Service update

Go Live Date for Maternity Clinical Information System

Concern was expressed at the risk of going live on the proposed date of 4 August. Management advised that whilst that was the proposed date, MDHB would not go live until all appropriate things were in place, eg contracts were in place and technical issues were resolved. MDHB did not want to sign up to any agreement or protocols until there was national support and agreement of the contracts.

6-15

Data Analysis

The significant improvement in the number of women registering with an LMC was noted.

Social Work Services

A member commented that services had to be more integrated.

It was recommended

that this report be received.

8. OPERATIONAL REPORTS

8.1 Provider Division Operating Report – November/December 2013

Management advised the provisional year end results showed that MCH had achieved budget for the month, meaning an overall unfavourable variance to budget for the year end of around $2.2m.

Patient Flow Improvement Programme

July was a reasonably busy month for the hospital. The focus on the relationship between ED and the sub-specialities continued. Work was also underway on the average length of stay in general medicine, as it had increased slightly. A mini discharge summary has been developed which should enable patients to leave hospital more quickly. The usual discharge summary is then sent out later in the day. Members were advised that the medical clinical director from Capital and Coast DHB would be coming to MCH to share CCDHB's successful processes and actions on 23 July.

Shorter Stays Result

Whilst some concern was expressed at MCH continuing to have the lowest result in the shorter stays target, the ED results for July so far were 91%, which was positive given it was winter. Management advised there had been real engagement between the clinical staff in ED and other parts of the hospital as the issue seemed to be moving patients out of ED into the rest of the hospital.

Management advised that whilst Whanganui DHB had an Accident and Medical, GP Service alongside ED, MCH's ED managed their patients within 95-96% of the SSIED target. The issue therefore, was not how the patients were managed in ED, but as noted earlier, was around moving those patients who needed to be admitted into hospital once a decision was made to admit them. The discharge processes and average length of stay times have crept up slightly recently and needed to be brought back to the national average.

Elective Services

Members were advised that as registrars have been covering many theatre sessions recently, the complex cases and hence the case weight value of the procedures undertaken would not be as high as it would have been if a senior consultant had done the work; therefore revenue may be down for July.

Retirement of Dr Ngaire Smidt

The Committee acknowledged Dr Smidt's retirement and the achievements she made while employed by the Board.

Child & Adolescent Oral Health

There was some discussion regarding the odour issues on two of the mobile units. Management outlined the review undertaken, the results of it and the actions being considered, eg mechanical ventilation. Whilst there was a low level of formaldehyde it did not represent a safety issue according to internationally recognised safety standards. A decision on what action would be taken in terms of the smell would consider the needs of staff and the most appropriate way of improving ventilation.

The slight increase in the DNA rate for the CAOHS was noted. It was confirmed a patient focused booking approach was used in terms of the integrated family health centre processes. It may not be the same as used for first specialist assessment appointments in ambulatory care, but the appointments were made in consultation with families and what suited them.

General Practitioner (GP) Sleep Service

Members were advised that a team would be going to Auckland the following day to look at the Auckland service, which is nurse lead. An update on that visit could be provided to the next meeting.

The "Pink Envelope"

This initiative has been well supported, and allows for better notes and communication between the hospital and aged residential care facilities.

Organisation Health and Learning Performance Summary (Appendix 4)

Members were advised the first two graphs on this appendix had been inadvertently inter-changed and should be swapped around. The information was correct.

Patients Seen and Referral Declines

It was suggested it would have been good to have information from the previous two years for comparison purposes. The member also felt it would be interesting to know how patients managed if they were declined. Management advised the management of patients who were declined was done by the patient's GP. Written care plans were provided, and non-contact FSAs were also done. The information provided in the report was to give an overview of the situation. Management agreed to provide information on the previous two years for the FSA referrals – accepted vs declines.

Maori Language Week

Members were advised a number of events had been organised for Maori Language Week through the Communications Department, eg on-line quizzes.

It was recommended

that this report be received.

9. LATE ITEMS

There were no late items.

10. DATE OF NEXT MEETING

2 September 2014

11. EXCLUSION OF PUBLIC

It was recommended

that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	*Reason*	*Reference*
"In Committee" minutes of the previous meeting	For reasons stated in the previous agenda	
Operations Report: : Potential Serious Adverse Events and Complaints	To protect personal privacy	9(2)(a)