MEMO

To:	Board Members
From:	Elizabeth Wood, Chair of Clinical Governance Committee
Date:	22 November 2017
Subject:	**Clinical Governance Report**

Status

This report contains:
☐ **For decision**
✓ **Update**
✓ **Regular report**
☐ **For information**

Key messages from Clinical Governance meeting held on 9 November 2017

DHB CGG approved:

- *Maternity Annual Report 2016* – The Maternity Quality and Safety Programme (MQSP) requires each DHB to provide an annual report on progress towards three New Zealand Maternity Standards, and 21 New Zealand Maternity Clinical Indicators. These cover the quality and safety of the service, access to services and a requirement to demonstrate consumer feedback and involvement in developing the service. Over 104 pages it demonstrates that NMDHB provides a safe, quality environment in which to give birth. Key areas to work on are:
  - Improving breastfeeding rates across the region – with a particular focus on vulnerable infants such as those requiring neonatal care
  - Improving referral rates particularly for vulnerable families to the five services that ensure continuity of care and support is assured after Lead Maternity Carer (LMC) care stops. These are: newborn enrolment with GP, community oral health, well child provider, new born hearing programme and national immunisation register
  - Rolling out the national 'Safe Sleep' programme
  - Gestational diabetes management – a more integrated MDT approach to care during pregnancy and increasing the uptake of HbA1c screening at 3 months post-partum. One in two women who get gestational diabetes go on to develop Type II diabetes within 5 years of the pregnancy, so ensuring they are appropriately monitored in primary care is a focus to help reduce this risk.

  There has been a substantial reduction in smoking rates in pregnancy, especially for Maori women and the use of the incentive program has seen excellent results.

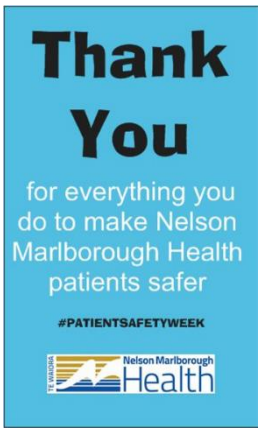
DHB CGG endorsed:

- *Global trigger tool (GTT): Quarter 4 Report* – This internationally recognised tool, to accurately measure and determine the most frequent causes of patient harm, has now been running in NMDHB for four years. A recent study carried out in three large tertiary care hospitals in the US found at least ten times more confirmed harm than other methods such as voluntary reporting. Their study found that there were 91 harm events per 1000 bed days. Using the tool provides us with more accurate data than that provided by voluntary reporting on the general level of safety in our hospitals and is reassuring regarding our level of harm events in comparison to others.

The value of the GTT is not in counting harms, but in using the data to identify themes or trends which appear to require further investigation and/or clinical audit with the view of improving patient care.

An important message from this quarter's report relates to medication related harm and specifically the importance of considering the possibility of a medication effect in the differential diagnosis when assessing a deteriorating patient.

- *Patient Safety Week* – The 5th to 11th of November is all about medication safety.

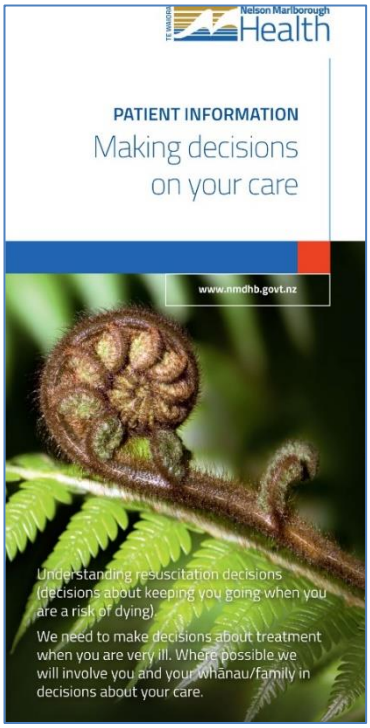


This links with the World Health Organisation's global patient safety challenge of 'Medication without Harm'. Our patients have reported, via the patient experience survey, that they do not always feel they have enough information about their medication side effects when they go home.

We want to encourage patients to ask questions about their medicines and staff to open the conversation. The role of the community pharmacist is also critical in addressing this.

The week is also about celebrating everything that we do already to keep patients safe – both in the hospital and in the community.

- *Shared Goals of Care* – ongoing trial of the OtTeR (Options for Treatment and Resuscitation) programme - The team attended the national deteriorating patient workshop run by the HQSC to ensure that our trial of establishing with patients their goals of care and the resulting options for treatment is aligned to the national direction. This is confirmed. The next steps for the project team are to establish the work plan for the next few months, present the findings of the audit of the trials so far to the next Clinical Governance Committee meeting and establish the training requirements. Essentially conversations must be conducted in a respectful, private environment, by a senior clinician, with documentation of the names and identity of everyone who was present and involved in making the decisions.



A new form is being developed to replace the current 'NFR' (Not for Resuscitation form) which will be clearer about the levels of active treatment such as IV fluids, inotropes (drugs to support the heart) or admission to ICU that are appropriate and desired by the patient and their treating team.

A booklet has also been developed to help patients to understand the decisions that are made.

This team is passionate that not only 'All people live well, get well, stay well' (our DHB vision) but that they should also be allowed and supported to 'Die well' in order to end, in the manner and situation of their choosing, a dignified and full life.

DHB CGG noted:

- *Quality and safety markers update, April – June 2017* – Nursing staff are to be congratulated for exceeding the HQSC (Health Quality and Safety Commission) target during this quarter for falls risk assessments and completion of an individualised care plan in those at risk that specifically addresses and manages the risk.

Elizabeth Wood
Clinical Director and Chair Clinical Governance Committee

RECOMMENDATION:

THAT THE BOARD RECEIVE THE CLINICAL GOVERNANCE REPORT.